



RESIDENT HEALTH ASSESSMENT FOR ASSISTED LIVING FACILITIES (ALF)

NAME:	DOB:
KNOWN ALLERGIES:	HEIGHT: WEIGHT:

HEALTH ASSESSMENT
Medical history and diagnoses:
Physical or sensory limitations:
Cognitive or behavioral status:
Nursing/treatment/therapy service requirements:
Special precautions:

To what extent does the individual need supervision/assistance with the following?

AMBULATION:	BATHING:	DRESSING:	TOILETING:
<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent
<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision
<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance
<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Incontinence
			<input type="checkbox"/> Catheter Care
			<input type="checkbox"/> Ostomy Assistance
EATING:	GROOMING:	TRANSFERRING:	
<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	
<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	
<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	
<input type="checkbox"/> Tube Feeding	<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Needs Total Help	

To what extent is the individual able to perform other self-care tasks such as preparing meals, shopping, or making phone calls?

Independent Needs Supervision Needs Assistance Needs Total Help

To what extent does the individual need general oversight such as observing the individual's well being and whereabouts and reminding the individual of important tasks?

Independent Weekly Oversight Daily Oversight _____ Other

Special Diet Instructions?

Regular Diabetic Diet No Added Salt Low Fat/Low Cholesterol

Other, please describe: _____

Please list all current medications prescribed (additional pages may be attached).

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.			
2			
3			
4			
5.			
6.			

Does the individual need help with their medications? Yes ___ No ____. If yes, please describe:

Does the individual have any of the following conditions/requirements? Circle the appropriate #:

#	STATUS	COMMENTS
1	A communicable disease which could be transmitted to other residents or staff?	
2	Bedridden?	
3	Any stage 2, 3, or 4 pressure sores?	
4	Pose a danger to self or others?	
5	Require 24-hour nursing or psychiatric care?	

In your professional opinion can this individual's needs be met in a residential facility that is not a medical, or nursing, or psychiatric facility (i.e., assisted living facility)? Yes ___ No ___

SIGNATURE: _____

MD or DO/ARNP

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION

DATE OF EXAMINATION:	- PLEASE RETURN COMPLETED FORM TO -
NAME OF EXAMINER (Printed):	NAME OF ALF:
MEDICAL LICENSE #:	CONTACT PERSON:
ADDRESS OF EXAMINER:	ADDRESS OF FACILITY:
PHONE #:	PHONE #: