

5. Personal Hygiene Assistance:

Yes	No	
_____	_____	Needs assistance with eating?
_____	_____	Needs assistance with grooming and dressing?
_____	_____	Needs assistance with bathing
_____	_____	Can self-administer medications without assistance?
_____	_____	Can self-administer medications with verbal reminders and limited staff assistance?
_____	_____	Continent?
		Other personal hygiene concerns?

6. Does resident have or has he/she had any communicable diseases such as:

Tuberculosis	___yes___no	If yes, date	_____
Hepatitis	___yes___no	If yes, date	_____
Other	___yes___no	If yes, date	_____

Last TB skin test and/or chest x-ray (required for admission within 30 days of move-in).

7. Medical summary/overall assessment:

8. PLEASE LIST CURRENT DIAGNOSIS:

Physician's Recommendation

___ Can live independently with some services

___ Can live in a licensed Assisted Living community where personal care needs can be met by non-nursing personnel

___ Requires professional nursing care and observation as is provided in a licensed, skilled nursing facility

Comments: _____

Physician's Signature _____

Name: _____

Address: _____

Phone: _____ Fax: _____ Date: _____