MEDICAL ASSESSMENT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

NOTE TO LICENSED MEDICAL PROFESSIONAL: The person/patient named below is either a prospective resident or resident of a Residential Care Facility for the Elderly (RCFE) licensed by the Department of Social Services. The licensee is required to provide primarily non-medical care and supervision to meet the needs of that person/patient. The information that you provide about this person/patient is required by law to assist in determining whether the person/patient is appropriate for care in this non-medical facility [California Code of Regulations (CCR), Title 22, Section 87458, Medical Assessment]. THESE FACILITIES CANNOT PROVIDE SKILLED NURSING CARE.

This form is provided as a courtesy to prospective residents/residents and licensees.

(Please attach separate pages if needed.)

I. FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY/FACILITY CONTACT PERSON	PHONE NUMBER	E-MAIL ADDRESS
Summerset Senior Living		
ADDRESS	CITY	ZIP CODE

II. PROSPECTIVE RESIDENT/RESIDENT INFORMATION (To be completed by the prospective resident/resident or prospective resident's/resident's legal representative)

NAME	DATE OF BIRTH	AGE
ADDRESS	CITY	ZIP CODE

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(To be completed by prospective resident/resident or prospective resident's/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

I acknowledge that by providing my electronic signature for this form, I agree my electronic signature is the legal binding equivalent to my handwritten signature. I hereby confirm that my electronic signature represents my execution of authentication of this form, and my intent to be bound by it.

SIGNATURE OF PROSPECTIVE RESIDENT/RESIDENT OR PROSPECTIVE RESIDENT'S/RESIDENT'S LEGAL REPRESENTATIVE	DATE

IV. PROSPECTIVE RESIDENT/RESIDENT INFORMATION
(To be completed by the licensed medical professional)

DATE OF EXAM	GENDER	HEIGHT	WEIGHT	BLOOD PRESSURE

DIAGNOSIS/DIAGNOSES

a. Please indicate the prospective resident's/resident's diagnosis/diagnoses:

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? Yes No
If no, describe what assistance is needed:

DEFINITIONS

Mild Cognitive Impairment (MCI): Refers to cognitive abilities that are in a "conditional state" between normal aging and dementia.

Major Neurocognitive Disorder (major NCD): Refers to substantially decreased cognitive or mental function due to a medical disease other than a psychiatric illness. Major NCD includes Alzheimer's disease and related disorders diagnosed by a licensed medical professional acting within their scope of practice. Related disorders considered to be major NCDs include, but are not limited to, vascular dementia, Lewy body dementia, Parkinson's disease, and frontotemporal dementia. Major NCDs cause impairment that is sufficient enough to interfere with independence in daily activities and may result in changes that include, but are not limited to, increased tendency to wander and decreased hazard awareness and ability to communicate.

COGNITIVE CONDITIONS

a. Does prospective resident/resident have any cognitive conditions? Yes No
If yes, please indicate cognitive condition(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? Yes No
If no, describe what assistance is needed:

RESULTS OF EXAM FOR COMMUNICABLE TUBERCULOSIS (TB)

DATE TB TEST GIVEN	DATE TB TEST READ	TYPE OF TB TEST	RESULTS OF TB TEST

Action taken (if positive):

RESULTS OF EXAM FOR INFECTIOUS DISEASES

a. Does prospective resident/resident have any infectious diseases? Yes No
If yes, please indicate infectious disease(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? Yes No
If no, describe what assistance is needed:

RESULTS OF EXAM FOR CONTAGIOUS DISEASES

a. Does prospective resident/resident have any contagious diseases? Yes No
If yes, please indicate contagious disease(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? Yes No
If no, describe what assistance is needed:

RESULTS OF EXAM FOR OTHER MEDICAL CONDITIONS

a. Does prospective resident/resident have any other medical conditions? Yes No
If yes, please indicate other medical condition(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? Yes No
If no, describe what assistance is needed:

ALLERGIES

a. Does prospective resident/resident have any allergies (e.g., seasonal, food, medication, dander)?
Yes No

If yes, please indicate allergy(ies): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? Yes No

If no, describe what assistance is needed:

1. OVERALL PHYSICAL HEALTH **GOOD** **FAIR** **POOR**

PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (If applicable)	EXPLAIN
a. Hearing Loss	○	○		
b. Vision Loss	○	○		
c. Wears Dentures	○	○		
d. Wears Prosthesis	○	○		
e. Special Diet	○	○		
f. Substance Abuse	○	○		
g. Use of Alcohol	○	○		
h. Use of Nicotine or Related Products	○	○		
i. Bowel Incontinence	○	○		
j. Bladder Incontinence	○	○		
k. Motor Impairment/Paralysis	○	○		
l. Requires Assistance with Repositioning and Transferring	○	○		
m. History of Skin Condition or Breakdown	○	○		

COMMENTS:

2. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self	○	○	
b. Able to Dress/Groom Self	○	○	
c. Able to Feed Self	○	○	
d. Able to Care for Own Toileting Needs	○	○	
e. Able to Manage Own Cash Resources	○	○	
f. Able to Communicate	○	○	
g. Able to Follow Directions/ Instructions	○	○	
h. Able to Leave Facility Unsupervised (considering physical or cognitive abilities); if no, please explain.	○	○	

COMMENTS:

3. OVERALL MENTAL HEALTH ○ **GOOD** ○ **FAIR** ○ **POOR**

MENTAL HEALTH STATUS	YES	NO	EXPLAIN
a. Depressed	○	○	
b. Suicidal Ideation	○	○	
c. Self-Abuse	○	○	
d. Other	○	○	

COMMENTS:

4. BEHAVIORAL EXPRESSIONS*	YES	NO	EXPLAIN
a. Disorientation	○	○	
b. Lack of Hazard Awareness	○	○	
c. Lack of Impulse Control	○	○	
d. Unsafe Wandering**	○	○	
e. Elopement***	○	○	
f. Expressions of Frustration	○	○	
g. Hallucinations	○	○	
h. Other	○	○	

* "Behavioral expression" means behavior or behaviors displayed by a resident that may result in harm to self or others including, but not limited to, unsafe wandering, or elopement, expressions of frustration, disorientation, hallucinations, or lacking in hazard awareness or impulse control. Behavioral expression may be due to boredom, fear, overstimulation, perceived threat, fatigue, physical discomfort, pain, "Major Neurocognitive Disorder (major NCD)", or other causes including, but not limited to, medication interactions and/or illnesses such as urinary tract infections.

** "Unsafe wandering" occurs when a resident at risk enters an area that is physically hazardous or contains items that are potential safety hazards. For example, unsafe wandering may occur when a resident enters another resident's room when doing so may lead to an altercation or contact with hazardous items.

***"Elopement" occurs when a resident who is at risk of harm due to their cognitive condition leaves the facility unsupervised, or while in the licensee's care, leaves another safe location unsupervised.

COMMENTS:

5. ACCESS TO ITEMS	YES	NO	EXPLAIN
Would the prospective resident's/ resident's or other resident's safety be at risk if the resident had access to the following items:	○	○	
a. Personal care and hygiene items	○	○	
b. Disinfectants, cleaning solutions, poisonous substances, knives, matches, tools, sharp objects, and other similar items which could pose a danger to residents.	○	○	
c. Nutritional supplements, vitamins, alcohol, cigarettes and other potentially toxic substances, such as certain plants, gardening supplies, and auto supplies.	○	○	
Does the prospective resident/resident require supervision by the licensee when in proximity to or when there is use of:	○	○	
a. Ranges, ovens, heaters, fireplaces, wood stoves, inserts, and other heating devices.	○	○	
b. Fishponds, wading pools, hot tubs, swimming pools, or similar large bodies of water.	○	○	
c. Birdbaths, fountains, or similar smaller decorative water features.	○	○	

COMMENTS:

6. MEDICATION MANAGEMENT	YES	NO	N/A	EXPLAIN
a. Able to Administer Own Prescription Medications	○	○	○	
b. Able to Administer Own Injections	○	○	○	
c. Able to Perform Own Glucose Testing	○	○	○	
d. Able to Administer Own PRN Medications	○	○	○	
e. Able to Administer Own Oxygen	○	○	○	
f. Able to Store Own Medications	○	○	○	

COMMENTS:

AMBULATORY STATUS:

a. 1. The prospective resident/resident is able to independently transfer to and from bed: Yes No

2. For purposes of a fire clearance, this prospective resident/resident is considered:

Ambulatory Nonambulatory Bedridden

Nonambulatory: The prospective resident/resident is unable to leave a building unassisted under emergency conditions. This includes, but is not limited to, a prospective resident/resident who depends upon mechanical aids such as crutches, walkers, and wheelchairs. It also includes a prospective resident/resident who is unable, or likely to be unable, to respond physically or mentally to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire or other dangers, and if unassisted, to take appropriate action relating to such danger.

Note: A prospective resident/resident who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a prospective resident/resident who requires assistance with turning or repositioning in bed.

b. If prospective resident/resident is nonambulatory, this status is based upon:

Physical Condition Mental Condition Both Physical and Mental Condition

c. If a prospective resident/resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

Illness: _____

Recovery from Surgery: _____

Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a prospective resident/resident is bedridden, how long is bedridden status expected to persist?

1. _____ (number of days)
2. _____ (estimated date illness or recovery is expected to end or when prospective resident/resident will no longer be confined to bed)
3. If illness or recovery is permanent, please explain:

e. Is prospective resident/resident receiving hospice care?

No Yes If yes, specify the terminal illness: _____

COMMENTS:

V. LICENSED MEDICAL PROFESSIONAL INFORMATION

I acknowledge that by providing my electronic signature for this form, I agree my electronic signature is the legal binding equivalent to my handwritten signature. I hereby confirm that my electronic signature represents my execution of authentication of this form, and my intent to be bound by it.

LICENSED MEDICAL PROFESSIONAL NAME AND ADDRESS (PRINT)	
PHONE NUMBER	E-MAIL ADDRESS
LENGTH OF TIME YOU HAVE PROVIDED CARE TO PROSPECTIVE RESIDENT/RESIDENT	
LICENSED MEDICAL PROFESSIONAL SIGNATURE	DATE