

Medication Allergies (with reaction): _____

Diet Instructions: Regular No added table salt No conc. Sweets Other

Explain Other: _____

STATUS OF THE FOLLOWING:

AMBULATING

- Independent
- Needs supervision
- Needs assistance
- Needs total help

BATHING

- Independent
- Needs supervision
- Needs assistance
- Needs total help

DRESSING

- Independent
- Needs supervision
- Needs assistance
- Needs total help

EATING

- Independent
- Needs supervision
- Needs assistance
- Needs total help

GROOMING

- Independent
- Needs supervision
- Needs assistance
- Needs total care

SKIN INTEGRITY

- Independent
- Needs supervision
- Needs assistance
- Needs total care

TOILETING

- Independent
- Needs supervision
- Needs assistance
- Needs total care

TRANSFERRING

- Independent
- Needs supervision
- Needs assistance
- Needs total care

RESTRAINTS

- Requires no restraints
- Requires chemical restraints Type: _____
- Requires physical restraints Type: _____

PHYSICIAN'S REPORT:

Check all that apply:

Yes No The individual has received screening for TB? **If yes**, Date and Results? _____ **(Proof of TB screen must be submitted)**

Yes No Does the individual's behavior pose a danger to self or others? **If yes**, can this behavior be controlled by medication(s)?: _____

Yes No Does the individual needs assistance from staff during the night? If yes, please describe:

Yes No Does the individual require 24 hour nursing supervision?

Yes No Based on the type of care the staff of a Personal Care Home may legally provide, the individual's needs can be met in a Personal Care Home for adults, which is not a medical facility?

Comments: _____

Name of Physician: _____ License Number: _____

Address: _____

Phone: _____ Date: _____

Signature of Physician: _____