# SUBSTITUTE FOR DSS-3122

## MEDICAL EVALUATION

(ALL SPACES MUST BE COMPLETED)

**STATEMENT OF PURPOSE**

Adult Residential Care Programs provide 24 hour residential care settings for dependent adults. They are not medical facilities. Persons in need of constant medical care and supervision should not be admitted or retained in an adult residential care facility because such a facility lacks the staff and expertise to provide needed services. Persons who, by reason of age and/or physical and/or mental limitations, are in need of assistance with the basic activities of daily living can be cared for in adult residential care settings.

The information solicited in this medical evaluation will assist you, the individual, and the operator of an adult residential care facility in determining the level of care needed to assure the health, safety and well being of the individual. It will become part of the resident's record and subject to review by the State Department of Social Services, which is responsible for supervision of the Adult Residential Care Programs.

**SECTION I - PERSONAL**

| NAME: | | | DATE OF BIRTH: |
|---|---|---|---|
| ADDRESS: | | | |
| CITY: | STATE: | ZIP CODE: | SEX: *(Check One)* ☐ M ☐ F |

**SECTION II – MEDICAL HISTORY**

| PRIMARY DIAGNOSIS: | SECONDARY DIAGNOSIS: |
|---|---|
| RECENT SURGERY: *(Type of Procedure)* ☐ None Known | RECENT ACUTE ILLNESS: *(Type and Date)* |
| DIET:<br>REGULAR [ ]<br>NO CONCENTRATED SWEETS [ ]<br>NO ADDED SALT [ ] | ALLERGIES TO: *(List any known)* ☐ None Known<br>MEDICATIONS: ☐ NONE<br>FOOD: ☐ NONE<br>OTHER: ☐ NONE<br>ACTIVITY RESTRICTIONS: ☐ NONE |
| WEIGHT BEARING:<br>FULL<br>PARTIAL<br>NONE | CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS:<br>BLOOD PRESSURE:<br>WEIGHT: |

REQUIRED MEDICAL EXAMINATIONS AND/OR COMMUNITY BASED MEDICAL SERVICES:

| REQUIRED NEED | PROVIDED BY | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| SECTION III: LIST ALL CURRENT MEDICATIONS (Prescriptions and OTC), AND NOTE SPECIAL INSTRUCTION: |
|---|
| MEDICATION: *(Type, Frequency and Dosage)* |

| SECTION IV: OBSERVATION OF INDIVIDUAL | | | |
|---|---|---|---|
| IS INDIVIDUAL: *(Please check either Yes or No)* | YES | NO | DESCRIBE AS NEEDED |
| AMBULATORY? | ☐ | ☐ | |
| CAPABLE OF SELF ADMINISTRATION OF MEDICATIONS? | ☐ | ☐ | |
| HABITUATED TO DRUGS? | ☐ | ☐ | |
| HABITUATED TO ALCOHOL? | ☐ | ☐ | |
| DANGER TO SELF OR OTHERS? | ☐ | ☐ | |
| FREE OF COMMUNICABLE DISEASE? | ☐ | ☐ | |
| INCONTINENT? | ☐ | ☐ | |

| SECTION V: EVALUATION |
|---|
| IN YOUR OPINION CAN THE INDIVUDAL'S NEEDS BE MET BY THE SUPPORT SERVICES AVAILABLE IN AN ADULT CARE FACILITY? ☐ YES ☐ NO *(Please Describe – Optional)* |
| DOES THE INDIVIDUAL REQUIRE PLACEMENT IN A NURSING FACILITY? ☐ YES ☐ NO *(If YES, Please give reasons)* |
| DOES THE INDIVIDUAL HAVE A RELEVANT HISTORY, CURRENT CONDITION OR RECENT HOSPITALIZATION FOR MENTAL ILLNESS? ☐ YES ☐ NO *(If YES, Explain)* |
| IF YES TO THE ABOVE QUESTION, DOES THE INDIVIDUAL REQUIRE A MENTAL HEALTH EVALUATION? ☐ YES ☐ NO |

| PHYSICIAN'S SIGNATURE: | DATE OF EXAMINATION: | DATE FORM WAS COMPLETED: |
|---|---|---|
| | | |