New York State Department of Health
Division of Home and Community Based Services

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Facility Name: _____ **Date of Exam:** _____

Patient's/Resident's Name: _____ Date of Birth:_____ Sex:_____

Present Home Address: _____
Street

_____
City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in patient condition

☐ Other (Describe): _____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse:_____ Resp: _____ T: _____ Height: _____ft _____in. Weight: _____

Primary Diagnosis(s): _____

Secondary Diagnosis(s): _____

Allergies: ☐ None Known Allergies (list): _____

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Mechanical Soft ☐ Other: _____

Does the resident have dental health concerns requiring treatment or which may impair chewing/eating? No ☐ Yes ☐

If yes, describe:_____

Tobacco Use: ☐ PPD/Years: _____ Alcohol Use: ☐ Amount/Frequency:_____

Recreational Drug Use: ☐ Describe_____

IMMUNIZATIONS

☐ Influenza (Date_____)
☐ Pneumococcal Vaccine (Date_____)
☐ Tetanus Vaccine (Date_____)

SCREENINGS

☐ Mammogram (Date_____)
☐ Pap Smear (Date_____)
☐ PSA (Date_____)
☐ Colonoscopy (Date_____)

TUBERCULIN TEST (*Required within 30 days prior to admission unless medically contraindicated)* ☐Test is contraindicated

☐ TST1:_____Date placed _____Date Read _____mm
☐ TST2:_____Date placed _____Date Read _____mm
☐ QuantiFERON-TB (QFT):_____Date Placed _____Date Read _____mm

Based on my findings and on my knowledge of this patient, I find that the patient _____ **IS** _____ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management:_____