DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Health Regulation
& Licensing Administration

899 North Capitol Street, NW
2nd Floor
Washington, D.C. 20002

Intermediate Care Facilities Division

Admission/Annual Medical Certification
(General and Special Permission Placement)

ALL SPACES MUST BE FILLED OUT

I certify the Assistance Living Residence Placement of

Facility Name: _____ **Date:** _____

Resident's Name: _____ DOB __ / __ / _____

Present Home Address: _____

1. REASON FOR EVALUATION : ☐ Pre-Admission ☐ 12 month ☐ Acute change in patient condition ☐ Emergency Admission (14 days)
☐Hospitalization/DX ☐Other Describe:_____ ☐ Short tem admissions (30 days)

Vital Signs: BP: _____ T: _____ R: _____ Pulse: _____ Height: _____ Weight: _____

Allergies: No Known Allergies Known Allergies**:** _____

Primary Diagnosis(es): _____ _____ _____

Secondary Diagnosis(es): _____ _____ _____

Tobacco Use: Yes Type/Frequency: _____ No

Alcohol Use: Yes Amount/Frequency: _____ No

Non-prescribed drugs:
Yes Type/Amount/Frequency: _____ No

Mammogram: Yes Date: _____ No **PSA** Yes Date: _____ No

Pap Test Yes Date: _____ No **Colonoscopy:** Yes Date: _____ No

2. IMMUNIZATION AND TESTS (Recommended but not required for admission.)

Influenza Vaccine Pneumoccocal Vaccine Tetanus Vaccine Other:_____ Yes - Date: _____ Yes - Date: _____ Yes - Date: _____ No No No Unknown Unknown Unknown

Tuberculin Test* Yes TST1 _____ Date Placed _____ Date Read _____ Mfr. _____ Lot # _____ _____ mm indurations

Yes TST2 _____ Date Placed _____ Date Read _____ Mfr. _____ Lot # _____ _____ mm indurations

QuantiFERON-TB (QFT) Result _____

No Unknown

** Required within 30 days of admission unless medically contraindicated.*

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.

3. Activities of Daily Living (ADLs) Does the patient need the assistance of another person to perform the following ADLs?

ADL	Needs assistance
Ambulate	No Yes Intermittent Continual
Transfer	No Yes Intermittent Continual
Eat No Yes Intermittent With Assistance Continual Tube-feeding, Specify	
Personal Care (Bathing, Dressing,Grooming) No Yes Total Care With Supervision With Assistance	

Diet: Regular No added salt

No concentrated sweets Mechanical soft Pureed

Other: _____

Continence:
Bladder Yes No If no, how is the incontinence managed?
_____

Bowel Yes No If no, how is the incontinence managed?
_____

A _____ B

Prosthesis: No Yes (describe) _____

Amputation: No Yes (describe) _____

Activity Restrictions: No Yes (describe) _____

Dependent on Medical Equipment: No Yes (describe) _____

_____ C

4. IMPAIRMENTS: VISION: Glasses: Yes No Glaucoma: L R Legally Blind: L R Contact Lenses: Yes No Cataract(s): L R Comments: _____

_____ D _____ E

_____ F _____

HEARING: Does the patient have a hearing deficit? Yes No Hearing aid: L R If yes, describe:

_____

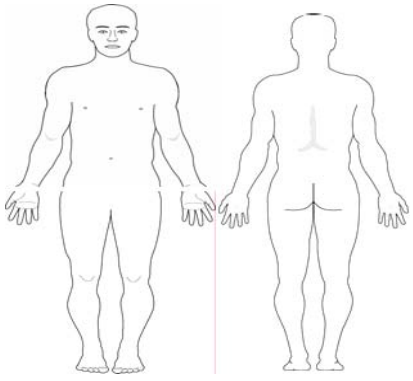
Comments: _____

SPEECH: Does the patient have a speech defect / impairment? Yes No

DENTAL: Does the patient have dental health concerns requiring treatment or which impair chewing/eating? No Yes If yes, describe_____ Does patient wear dentures? No Yes Upper Lower

PODIATRIC: Does the patient have podiatric concerns requiring treatment or which impair ability to ambulate or transfer? No Yes If yes, describe_____

5. SKIN: Does the patient exhibit signs or symptoms of any skin conditions which require treatment, e.g. wounds, bruises, rashes? No Yes If Yes, indicate the type, location and stage of the wound or skin condition on the model below.



A _____

B _____

C _____

D _____

E _____

F _____

6. PAIN RATING SCALE

Does the patient experience acute and/or chronic pain? No Yes Cause of pain: _____

Type (circle): Ache Tingling Burn Throb Pull Sharp Location: _____

Frequency (circle): Intermittent Nighttime Constant Duration: _____

Intensity (circle):

0 1-2 3-4 5-6 7-8 9-10

7. COGNITIVE IMPAIRMENT/MEMORY LOSS

Does the patient's medical history and/or diagnosis indicate dementia, cognitive impairment or memory loss?

☐No ☐Yes (describe)_____

If the patient is screened for dementia during this examination, indicate the tool used, the date and the patient's score.

Instrument Date Score Date of Previous Score of Previous
Screen (if known**) Screen** (if known)
Mini Mental _____ _____ _____ _____
Short Portable Mental Status
Questionnaire (SPMSQ) _____ _____ _____ _____
Other: _____ _____ _____ _____ _____
Comments: _____
_____

Based on your examination and/or information from caregivers, do you recommend the patient be screened and/or tested for dementia or cognitive impairment?

☐No ☐Yes (describe

8. **BEHAVIOR**

Cooperative
Combative
Wanders
Occasional Supervision
Constance Direction
Other

9. MENTAL HEALTH

Does the patient have a history of or a current mental disability? Yes No **Has the patient ever been hospitalized for mental health condition?** Yes No If Yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation?

No Yes Describe: _____

Comments: _____

10. SELF MEDICATE

Based on your evaluation is the resident able to self medicate

Yes
Yes With Supervision
Yes With Assistance

NOTE: The resident is NOT capable of self administration of medications if he/she needs assistance to properly carry out ONE OR MORE of the below (please indicate finding as to resident ability to) No Yes correctly read the label on a medication container. No Yes Correctly follow instructions as to route, time, dosage and frequency. No Yes Correctly ingest, inject or apply the medication. No Yes Open the container. No Yes Measure or prepare medications, including mixing, shaking and filling syringes. No Yes safely store the medication. No Yes correctly interpret the label.

11. MEDICATION (List all prescription and OTC medications, supplements and vitamins)

Attach additional sheet if necessary.

Medication	Dosage	Type	Frequency	Route	Diagnosis	Prescriber (name of	Needs assistance with administration
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No

12. REQUIRED SERVICES: (List all that are needed) Attach additional sheet if necessary

Medical Evaluation: Yes No

Type Reason Frequency/Duration: _____ Provided By: _____

Laboratory Services: Yes No

Type Reason Frequency/Duration: _____ Provided By: _____

STATEMENT OF PURPOSE: Assisted Living Residences (ALR) provide 24-hour residential care for adults. They are not medical facilities. Persons in need of constant medical care and medical supervision should not be admitted or retained in these settings because the facilities lack the staff and expertise to provide needed services. These settings are for persons who, by reason of age and/or physical and/or mental limitations are in need of assistance with activities of daily living, and can be cared for in the adult residential care settings listed above.

ALRs with advanced training (Licensed Practical Nurse) may serve people who need chronic assistance from another person with ambulation, transfer, ascending / descending stairs; are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or have chronic, unmanaged urinary or bowel incontinence. I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual:

Community Residence Facility (CRF) is a facility that provider a sheltered loving environment to residents that are able to perform the activities of daily living with minimal assistance, generally be oriented as to person, place and capable of proper judgment in tacking action for self-preservation under emergencies conditions.

IS **IS NOT** in need of continual acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home.

IS **IS NOT** in need of 24-hour skilled nursing care.

Signature: _____ Date: _____

Physician/Nurse Practitioner

LEVEL OF CARE RECOMMENDATION:

Assisted Living Residence Skilled Nursing Care Community Residence Facility