Physician's Report (California)

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

1. NAME OF FACILITY:	2. LICENSEE'S NAME:
3. ADDRESS NUMBER STREET CITY ZIP CODE	
4. TELEPHONE:	5. FAX NUMBER / 6. FACILITY LICENSE NUMBER

II. RESIDENT INFORMATION ***(To be completed by the resident/resident's responsible person):***

1. NAME	2. BIRTHDATE	3. AGE

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

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

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE	2. ADDRESS`	3. DATE

IV. PATIENT'S DIAGNOSIS ***(To be completed by the physician):***

NOTE TO PHYSICIAN: The person is either a resident or prospective resident of an assisted living facility. Please complete all of the information below. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care. This is not a skilled nursing facility.

1. DATE OF EXAM:	2. SEX:	3. HEIGHT:	4. WEIGHT:	5. BLOOD PRESSURE:

6. TUBERCULOSIS (TB) TEST (upon admission only)

a. DATE TB TEST GIVEN	b. DATE TB TEST READ	c. TYPE OF TB TEST	d. CHECK IF TB TEST IS: ☐ POSITIVE ☐ NEGATIVE

e. RESULTS: mm _____ f. ACTION TAKEN (IF POSITIVE): _____

g. Chest X-ray results: _____

h. PLEASE CHECK ONE OF THE FOLLLOWING: ☐ Active TB Disease ☐ Latent TB Infection ☐ No evidence of TB infection or disease

7. PRIMARY DIAGNOSIS:

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

b. Can patient manage own treatment/medication/equipment? ☐ yes ☐ no If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):

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

b. Can patient manage own treatment/medication/equipment? ☐ yes ☐ no If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

☐ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☐ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgment and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:

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

b. Can patient manage own treatment/medication/equipment? ☐ yes ☐ no If not, what type of medical supervision is needed?

11. ALLERGIES:

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

b. Can patient manage own treatment/medication/equipment? ☐ yes ☐ no If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:

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

b. Can patient manage own treatment/medication/equipment? ☐ yes ☐ no If not, what type of medical supervision is needed?

13. PHYSICAL HEATH STATUS	YES	NO	ASSISTIVE DEVICE:	COMMENTS:
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use of Alcohol				
h. Use of Cigarettes				
i. Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment/Paralysis				
l. Requires Continuous Bed Care				
m. History of Skin Condition/Breakdown				

14. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented			
b. Inappropriate Behavior			
c. Aggressive Behavior			
d. Wandering Behavior			
e. Sundowning Behavior			
f. Able to follow Instructions			
g. Depressed			
h. Suicidal/Self-Abuse			
i. Able to Communicate Needs			
j. At Risk if Allowed Direct Access to Personal Hygiene Items			

15. 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 Resource			

16. ESCORT REQUIREMENTS (check all that apply)

When leaving the Community, this resident:

- ☐ Should be escorted by staff due to cognitive impairment.
- ☐ Should be escorted by staff due to physical impairment.
- ☐ May be dropped off and later picked up by the Community van, leaving them unescorted for shopping visits, outings, appointments, etc.
- ☐ May leave independently with no escort, using public transportation or walking where desired.
- ☐ May drive his/her own vehicle.

17. NEED TO MONITOR EXITS (if patient has a diagnosis of dementia or related disorder)

This question ONLY applies if this patient has a diagnosis of dementia or related disorder. We wish to clarify the need to monitor exiting for them. If your resident has a diagnosis of dementia, please check one of the options below:

- ☐ Exiting does not present a hazard to my patient. He/she does not require additional monitoring while in the Community.
- ☐ Exits must be alarmed or an egress alert device, such as a WanderGuard wristband must be used. My patient is not able to leave the Community without supervision.
- ☐ Not applicable. Patient does not have a diagnosis of dementia or related disorder.

18. MEDICATION MANAGEMENT	YES	NO	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 Meds.			
e. Able to Administer Own Oxygen			
f. Able to Store Own Medications			

19. AMBULATORY STATUS

a. 1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered: ☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire marshal, or to an oral instruction relating to fire danger, and/or a person who depends upon mechanical aids such as crutches, walkers, and wheelchairs.

Note: A person 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 nonambulatory for the purposes of fire clearance.

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

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

☐ Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition

c. If 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 injury is considered temporary if it will last 14 days or less.

d. If a 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 resident will no longer be confined to bed)
3. If illness or recovery is permanent, please explain: _____

20. HOSPICE

Is resident receiving hospice care?

☐ No ☐ Yes If yes, specify the terminal illness: _____

21. PHYSICAL HEALTH STATUS

The resident's physical health status is: ☐ Good ☐ Fair ☐ Poor

22. COMMENTS

23. PHYSICIAN SIGNATURE AND ADDRESS

PHYSICIAN'S NAME AND ADDRESS (PRINT):	
TELEPHONE:	LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT:
PHYSICIAN'S SIGNATURE:	DATE: