



**RESIDENT HEALTH ASSESSMENT FOR ASSISTED LIVING FACILITIES (ALF)**

NAME:	DOB:
KNOWN ALLERGIES:	HEIGHT:                      WEIGHT:

<b>HEALTH ASSESSMENT</b>
Medical history and diagnoses:
Physical or sensory limitations:
Cognitive or behavioral status:
Nursing/treatment/therapy service requirements:
Special precautions:

**To what extent does the individual need supervision/assistance with the following?**

<b>AMBULATION:</b>	<b>BATHING:</b>	<b>DRESSING:</b>	<b>TOILETING:</b>
<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent
<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision
<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance
<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Incontinence
			<input type="checkbox"/> Catheter Care
			<input type="checkbox"/> Ostomy Assistance
<b>EATING:</b>	<b>GROOMING:</b>	<b>TRANSFERRING:</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	
<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	<input type="checkbox"/> Needs Supervision	
<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Assistance	
<input type="checkbox"/> Tube Feeding	<input type="checkbox"/> Needs Total Help	<input type="checkbox"/> Needs Total Help	

**To what extent is the individual able to perform other self-care tasks such as preparing meals, shopping, or making phone calls?**

Independent       Needs Supervision       Needs Assistance       Needs Total Help

**To what extent does the individual need general oversight such as observing the individual's well being and whereabouts and reminding the individual of important tasks?**

Independent       Weekly Oversight       Daily Oversight       Other

**Special Diet Instructions?**

Regular       Diabetic Diet       No Added Salt       Low Fat/Low Cholesterol

Other, please describe: \_\_\_\_\_

Please list all current medications prescribed (additional pages may be attached).

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.			
2			
3			
4			
5.			
6.			

Does the individual need help with their medications? Yes \_\_\_ No \_\_\_\_. If yes, please describe:

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Does the individual have any of the following conditions/requirements? Circle the appropriate #:

#	STATUS	COMMENTS
1	A communicable disease which could be transmitted to other residents or staff?	
2	Bedridden?	
3	Any stage 2, 3, or 4 pressure sores?	
4	Pose a danger to self or others?	
5	Require 24-hour nursing or psychiatric care?	

In your professional opinion can this individual's needs be met in a residential facility that is not a medical, or nursing, or psychiatric facility (i.e., assisted living facility)? Yes \_\_\_ No \_\_\_

SIGNATURE: \_\_\_\_\_

MD or DO/ARNP

**NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION**

DATE OF EXAMINATION:	- PLEASE RETURN COMPLETED FORM TO -
NAME OF EXAMINER (Printed):	NAME OF ALF:
MEDICAL LICENSE #:	CONTACT PERSON:
ADDRESS OF EXAMINER:	ADDRESS OF FACILITY:
PHONE #:	PHONE #: