RESIDENT HISTORY AND PHYSICAL FORM

REPORT OF RESIDENT'S PHYSICAL EXAM – (to be completed by resident's physician within 30 days prior to date of acceptance for admission. Report to be part of resident's permanent record.)

____
Name   Address

                                        ____
                                        Telephone Number

1. **Date of Physical Examination:** ________________

Place of Examination:
______ Office ______ Hospital _____Other
(specify hospital) ______________________

BP ____________ TEMP ______________ PULSE _________ RSP _______

DIAGNOSIS/SIGNIFICANT:

Primary: ____
Contributory: ____
Secondary: ____
Present level of cognitive functioning: __________________________

GENERAL APPEARANCE:

EENT: ____
Neck: ____
Chest: ____
Heart: ____
Abdomen: ____
Extremities: ____
Skin: ____
Pelvic: ____
Rectal: ____
Height: _______________ Weight: ___________________________

HISTORY OF ILLNESSES:

Diabetes ______ Seizures _____ Dizziness ______ Arthritis _____
CVA ______ Heart Disease _____ Cancer ______ Allergy _____
TB ______ Kidney Disease_____ Other __________________________

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PLEASE LIST ANY PREVIOUS HOSPITALIZATIONS FOR INJURY, SURGERY, ILLNESSES, ETC: ____

____

PLEASE LIST ALL KNOWN ALLERGIES (Medicine, Food, etc.):

____

2. (A) Date of screening for TUBERCULOSIS according to accepted methods of VA Department of Health: ____
   (B) Type of test: ____
   (C) Test results: ____

Standards permit the initial screening for TB to be tuberculin skin test. Each person, whose physician certifies the absence of TB in a communicable form, even though the test is positive, must obtain a chest x-ray on an annual basis for the following two (2) years.

   (D) This person is _____, is not _____ free of TB in a communicable form.
   (E) If it is medically inappropriate for this person to have a TB test, please check. _____

The patient must be tested for TB no more than 30 days prior to admission to the facility.

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3. **RECOMMENDATIONS FOR CARE:**
   (A) Diet (choose one):
   regular _____ no salt added _____ no concentrated sweets _____
   (B) Specific treatments/therapy: ____
   ____
   (C) Medications: ____
   ____
   (D) Mental Condition:
   Hospitalization for mental illness: ____

   If so, what type: ____
   When & how many times: ____
   Results? ____

   Any h/o aggressive behavior or dangerously agitated states? ___________
   Senility: Slight _____ Moderate _____ Advanced ______
   H/O drug addiction or excessive ETOH intake? ___________

   Mental Health After Care/Follow Along Service Requirements if Appropriate: (completion required for persons being discharged from a State Program for the Mentally Ill or Mentally Retarded).______________

   ____

   (E) Other: ____

   ____

Amerisist is licensed by the Department of Social Services, Commonwealth of Virginia, in accordance with Section 22 VAC 40-71-150 of the Standards and Regulations for Licensed Adult Care Residence, no person who is in need of skilled nursing care shall be admitted.

1. In your opinion, does this individual need skilled nursing care? Yes ____ No ___

2. In your opinion, can this individual's needs be met in an Adult Care Residence? Yes _____ No _____

3. In your opinion, is this individual bedfast (confined or restricted to bed for prolonged or indefinite periods)? Yes _____ No _____

4. Does this person need any type of restraint to provide physical support because of a weakened condition? Yes _____ No _____

5. Is this person capable of administering his/her own medication without assistance? Yes _____ No _____

6. (A) In your opinion, is this individual physically and mentally capable of self preservation by evacuating to an emergency refuge area without the assistance from another person, or from the facility itself without the assistance of another person, even if the individual may require the assistance of a wheelchair, walker, cane, prosthetic device or a single verbal command to evacuate? Yes _____ No _____

   (B) In your opinion, does this person have the sensory and mental ability to perceive an emergency and make an exit from the building, including ascent or descent of stairs, without the assistance of another person? Yes _____ No _____

Does this individual have any of the following conditions or care needs?

Condition/Care Need	Yes	No	Comment________________
Ventilator dependency			
Dermal ulcers III and IV			
Intravenous therapy or injections directly into the vein			
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission			

Condition/Care Need	YES	NO	Comment
Psychotropic medication Without appropriate diagnosis & treatment plans			
Nasogastric tubes			
Gastric tube			If yes, is person capable of independently feeding himself & caring for tube?
Presents imminent physical threat or danger to self or others			
Requires continuous licensed nursing care			

Comments: ____

____

____

______________________________ Date: _______________
Physician's signature

Please print or type Physician's name, address & telephone number here:

Name: ____

Address: ____

____

Phone #: ____