

PREPLACEMENT APPRAISAL INFORMATION

Admission - Residential Care Facilities

NOTE: This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).

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|------------------|-----|
| APPLICANT'S NAME | AGE |
|------------------|-----|

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness; participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| <input type="checkbox"/> OUT OF BED ALL DAY <input type="checkbox"/> IN BED ALL OR MOST OF THE TIME <input type="checkbox"/> IN BED PART OF THE TIME | COMMENT: |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|

TUBERCULOSIS INFORMATION

| | | |
|----------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|
| ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY? <input type="checkbox"/> YES <input type="checkbox"/> NO | DATE OF TB TEST | <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE |
| ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? <input type="checkbox"/> YES <input type="checkbox"/> NO | ACTION TAKEN (IF POSITIVE) | |

GIVE DETAILS

AMBULATORY STATUS (this person is ambulatory nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

- | YES | NO | |
|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane. |
| <input type="checkbox"/> | <input type="checkbox"/> | Mentally and physically able to follow signals and instructions for evacuation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Able to use evacuation routes including stairs if necessary. |
| <input type="checkbox"/> | <input type="checkbox"/> | Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation). |

FUNCTIONAL CAPABILITIES (Check all items below)

- | YES | NO | |
|--------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Active, requires no personal help of any kind - able to go up and down stairs easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Active, but has difficulty climbing or descending stairs |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses brace or crutch |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeble or slow |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses walker. If Yes, can get in and out unassisted? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses wheelchair. If Yes, can get in and out unassisted? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Requires grab bars in bathroom |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: (Describe) _____ |

SERVICES NEEDED (Check items and explain)

- | YES | NO | |
|--------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Help in transferring in and out of bed and dressing _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with bathing, hair care, personal hygiene _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does client desire and is client capable of doing own personal laundry and other household tasks (specify) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with moving about the facility _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with eating (need for adaptive devices or assistance from another person) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Special diet/observation of food intake _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Toileting, including assistance equipment, or assistance of another person _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with medication _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help in managing own cash resources _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help in participating in activity programs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Special medical attention _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Assistance in incidental health and medical care _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other "Services Needed" not identified above _____ |

Is there any additional information which would assist the facility in determining applicant's suitability for admission? Yes No

If Yes, please attach comments on separate sheet.

To the best of my knowledge; I (the above person) do not need skilled nursing care.

| | |
|-------------------------------------------------|----------------|
| SIGNATURE | DATE COMPLETED |
| APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE | |
| SIGNATURE | DATE COMPLETED |
| LICENSEE OR DESIGNATED REPRESENTATIVE | DATE COMPLETED |