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).*

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(Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))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

☐ OUT OF BED ALL DAY ☐ IN BED ALL OR MOST OF THE TIME ☐ IN BED PART OF THE TIME	COMMENT:

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY? ☐ YES ☐ NO	DATE OF TB TEST	☐ POSITIVE ☐ NEGATIVE
ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? ☐ YES ☐ 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	
☐	☐	Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
☐	☐	Mentally and physically able to follow signals and instructions for evacuation.
☐	☐	Able to use evacuation routes including stairs if necessary.
☐	☐	Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

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

_____

SERVICES NEEDED (Check items and explain)

YES	NO	
☐	☐	Help in transferring in and out of bed and dressing_____
		_____
☐	☐	Help with bathing, hair care, personal hygiene _____
☐	☐	Does client desire and is client capable of doing own personal laundry and other household tasks (specify) _____
☐	☐	Help with moving about the facility _____
		_____
☐	☐	Help with eating (need for adaptive devices or assistance from another person)_____
		_____
☐	☐	Special diet/observation of food intake _____
		_____
☐	☐	Toileting, including assistance equipment, or assistance of another person_____
☐	☐	Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____
☐	☐	Help with medication _____
		_____
☐	☐	Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____
☐	☐	Help in managing own cash resources _____
☐	☐	Help in participating in activity programs_____
		_____
☐	☐	Special medical attention _____
		_____
☐	☐	Assistance in incidental health and medical care _____
		_____
☐	☐	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