

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health

Health Regulation  
& Licensing Administration



899 North Capitol Street, NW  
2<sup>nd</sup> Floor  
Washington, D.C. 20002

Intermediate Care Facilities Division

Admission/Annual Medical Certification  
(General and Special Permission Placement)

ALL SPACES MUST BE FILLED OUT

I certify the Assistance Living Residence Placement of

Facility Name: \_\_\_\_\_ Date: \_\_\_\_\_

Resident's Name: \_\_\_\_\_ DOB \_\_ / \_\_ / \_\_\_\_

Present Home Address: \_\_\_\_\_

1. REASON FOR EVALUATION :  Pre-Admission  12 month  Acute change in patient condition  Emergency Admission (14 days)  
 Hospitalization/DX  Other Describe: \_\_\_\_\_  Short tem admissions (30 days)

Vital Signs: BP: \_\_\_\_\_ T: \_\_\_\_\_ R: \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies:  No Known Allergies Known Allergies: \_\_\_\_\_

Primary Diagnosis(es): \_\_\_\_\_

Secondary Diagnosis(es): \_\_\_\_\_

Tobacco Use:  Yes Type/Frequency: \_\_\_\_\_  No

Alcohol Use:  Yes Amount/Frequency: \_\_\_\_\_  No

Non-prescribed drugs: \_\_\_\_\_  
 Yes Type/Amount/Frequency: \_\_\_\_\_  No

Mammogram:  Yes Date: \_\_\_\_\_  No PSA  Yes Date: \_\_\_\_\_  No

Pap Test  Yes Date: \_\_\_\_\_  No Colonoscopy:  Yes Date: \_\_\_\_\_  No

2. IMMUNIZATION AND TESTS (Recommended but not required for admission.)

Influenza Vaccine Pneumococcal Vaccine Tetanus Vaccine Other: \_\_\_\_\_  Yes - Date: \_\_\_\_\_  Yes - Date: \_\_\_\_\_  
\_\_\_\_\_  Yes - Date: \_\_\_\_\_  No  No  No  Unknown  Unknown  Unknown

Tuberculin Test\*  Yes TST1 \_\_\_\_\_ Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_ Mfr. \_\_\_\_\_ Lot # \_\_\_\_\_  
\_\_\_\_\_ mm indurations

Yes TST2 \_\_\_\_\_ Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_ Mfr. \_\_\_\_\_ Lot # \_\_\_\_\_  
\_\_\_\_\_ mm indurations

QuantiFERON-TB (QFT) Result \_\_\_\_\_

No  Unknown

\* **Required within 30 days of admission unless medically contraindicated.**

Based on my findings and on my knowledge of this patient, I find that the patient \_\_\_\_\_ IS \_\_\_\_\_ IS NOT exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

**3. Activities of Daily Living (ADLs ) Does the patient need the assistance of another person to perform the following ADLs?**

ADL	Needs assistance
Ambulate	No <input type="checkbox"/> Yes <input type="checkbox"/> Intermittent <input type="checkbox"/> Continual <input type="checkbox"/>
Transfer	No <input type="checkbox"/> Yes <input type="checkbox"/> Intermittent <input type="checkbox"/> Continual <input type="checkbox"/>
Eat	No <input type="checkbox"/> Yes <input type="checkbox"/> Intermittent <input type="checkbox"/> With Assistance <input type="checkbox"/> Continual <input type="checkbox"/> Tube-feeding, Specify _____
Personal Care (Bathing, Dressing, Grooming)	No <input type="checkbox"/> Yes <input type="checkbox"/> Total Care <input type="checkbox"/> With Supervision <input type="checkbox"/> With Assistance <input type="checkbox"/>

Diet:  Regular  No added salt

No concentrated sweets  Mechanical soft  Pureed

Other: \_\_\_\_\_

**Continence:**

Bladder  Yes  No If no, how is the incontinence managed?  
\_\_\_\_\_

Bowel  Yes  No If no, how is the incontinence managed?  
\_\_\_\_\_

A \_\_\_\_\_ B

**Prosthesis:**  No  Yes (describe) \_\_\_\_\_

**Amputation:**  No  Yes (describe) \_\_\_\_\_

**Activity Restrictions:**  No  Yes (describe) \_\_\_\_\_

**Dependent on Medical Equipment:**  No  Yes (describe) \_\_\_\_\_

\_\_\_\_\_ C

**4. IMPAIRMENTS: VISION:** Glasses:  Yes  No Glaucoma: L  R  Legally Blind: L  R  Contact Lenses:  Yes  No Cataract(s):

L  R  Comments: \_\_\_\_\_

\_\_\_\_\_ D \_\_\_\_\_ E  
\_\_\_\_\_ F \_\_\_\_\_

**HEARING:** Does the patient have a hearing deficit? Yes  No  Hearing aid: L  R  If yes, describe:  
\_\_\_\_\_

Comments: \_\_\_\_\_

**SPEECH:** Does the patient have a speech defect / impairment? Yes  No

**DENTAL:** Does the patient have dental health concerns requiring treatment or which impair chewing/eating? No  Yes  If yes,

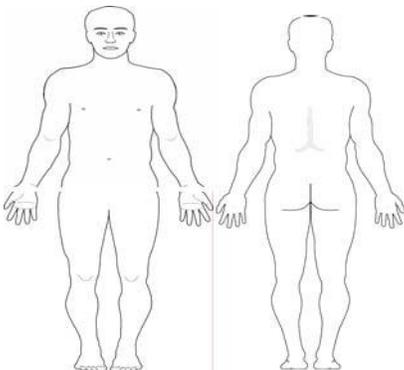
describe \_\_\_\_\_ Does patient wear

dentures?  No  Yes  Upper  Lower

**PODIATRIC:** Does the patient have podiatric concerns requiring treatment or which impair ability to ambulate or transfer? No  Yes  If yes, describe \_\_\_\_\_

**5. SKIN:** Does the patient exhibit signs or symptoms of any skin conditions which require treatment, e.g. wounds, bruises, rashes?

No  Yes  If Yes, indicate the type, location and stage of the wound or skin condition on the model below.



A \_\_\_\_\_

B \_\_\_\_\_

C \_\_\_\_\_

D \_\_\_\_\_

E \_\_\_\_\_

F \_\_\_\_\_

## 6. PAIN RATING SCALE

Does the patient experience acute and/or chronic pain?

No  Yes  Cause of pain: \_\_\_\_\_

Type (circle): Ache Tingling Burn Throb Pull

Sharp Location: \_\_\_\_\_

Frequency (circle): Intermittent Nighttime

Constant Duration: \_\_\_\_\_

Intensity (circle):

0 1-2 3-4 5-6 7-8 9-10

## 7. COGNITIVE IMPAIRMENT/MEMORY LOSS

Does the patient's medical history and/or diagnosis indicate dementia, cognitive impairment or memory loss?

No  Yes (describe) \_\_\_\_\_

If the patient is screened for dementia during this examination, indicate the tool used, the date and the patient's score.

Instrument Date Score Date of Previous Score of Previous

Screen (if known) Screen (if known)

Mini Mental \_\_\_\_\_

Short Portable Mental Status

Questionnaire (SPMSQ) \_\_\_\_\_

Other: \_\_\_\_\_

Comments: \_\_\_\_\_

Based on your examination and/or information from caregivers, do you recommend the patient be screened and/or tested for dementia or cognitive impairment?

No  Yes (describe)

## 8. BEHAVIOR

- Cooperative
- Combative
- Wanders
- Occasional Supervision
- Constance Direction
- Other

## 9. MENTAL HEALTH

Does the patient have a history of or a current mental disability? Yes  No  Has the patient ever been hospitalized for mental health condition? Yes  No  If Yes, describe: \_\_\_\_\_

Based on your examination, would you recommend the patient seek a mental health evaluation?

No  Yes Describe: \_\_\_\_\_

Comments: \_\_\_\_\_

## 10. SELF MEDICATE

Based on your evaluation is the resident able to self medicate

- No  Yes
- No  Yes With Supervision
- No  Yes With Assistance

**NOTE:** The resident is NOT capable of self administration of medications if he/she needs assistance to properly carry out ONE OR MORE of the below (please indicate finding as to resident ability to)  No  Yes correctly read the label on a medication container.  No  Yes Correctly follow instructions as to route, time, dosage and frequency.  No  Yes Correctly ingest, inject or apply the medication.  No  Yes Open the container.  No  Yes Measure or prepare medications, including mixing, shaking and filling syringes.  No  Yes safely store the medication.  No  Yes correctly interpret the label.

**11. MEDICATION (List all prescription and OTC medications, supplements and vitamins)**

Attach additional sheet if necessary.

Medication	Dosage	Type	Frequency	Route	Diagnosis	Prescriber (name of)	Needs assistance with administration
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No

**12. REQUIRED SERVICES: (List all that are needed)** Attach additional sheet if necessary

**Medical Evaluation:** Yes No

Type Reason Frequency/Duration: \_\_\_\_\_ Provided By: \_\_\_\_\_

**Laboratory Services:** Yes No

Type Reason Frequency/Duration: \_\_\_\_\_ Provided By: \_\_\_\_\_

**STATEMENT OF PURPOSE:** Assisted Living Residences (ALR) provide 24-hour residential care for adults. They are not medical facilities. Persons in need of constant medical care and medical supervision should not be admitted or retained in these settings because the facilities lack the staff and expertise to provide needed services. These settings are for persons who, by reason of age and/or physical and/or mental limitations are in need of assistance with activities of daily living, and can be cared for in the adult residential care settings listed above.

ALRs with advanced training ( Licensed Practical Nurse) may serve people who need chronic assistance from another person with ambulation, transfer, ascending / descending stairs; are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or have chronic, unmanaged urinary or bowel incontinence. I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual:

Community Residence Facility (CRF) is a facility that provider a sheltered loving environment to residents that are able to perform the activities of daily living with minimal assistance, generally be oriented as to person, place and capable of proper judgment in tacking action for self-preservation under emergencies conditions.

IS IS NOT in need of continual acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home.

IS IS NOT in need of 24-hour skilled nursing care.

Signature: \_\_\_\_\_  
Physician/Nurse Practitioner

Date: \_\_\_\_\_

**LEVEL OF CARE RECOMMENDATION:**

Assisted Living Residence

Skilled Nursing Care

Community Residence Facility