Resident Name _____ Date Completed _____
Date of Birth _____

Physical Assessment Form

This form is to be completed by a primary physician, certified nurse practitioner, registered nurse, or physician assistant. Questions noted with an asterisk are “triggers” for awake overnight staff.

Please note the following before filling out this form: Crystal Care Group(CCG) may not provide services to a resident who, at the time of initial admission, as established by the initial assessment, requires:
(1) More than intermittent nursing care;
(2) Treatment of stage three or stage four skin ulcers;
(3) Ventilator services;
(4) Skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition;
(5) Monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; or
(6) Treatment for a disease or condition that requires more than contact isolation. An exception to the conditions listed above may be made for residents who are under the care of a licensed general hospice program.

1.* Current Medical and Psychiatric History. Briefly describe recent changes in health or behavioral status, suicide attempts, hospitalizations, falls, etc., within the past 6 months.

2.* Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

Resident Name _____ Date Completed _____
Date of Birth _____

3. Allergies. List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem (e.g., rash, anaphylactic reaction, GI symptom, etc.). Please enter medication allergies here and also in Item 12 for medication allergies.

4. Communicable Diseases. Is the resident free from communicable TB and any other active reportable airborne communicable disease(s)?

(Check one) __Yes __No

If "No," then indicate the communicable disease: _____

Which tests were done to verify the resident is free from active TB?
PPD Date: _____ Result:_____mm
Chest X-Ray (if PPD positive or unable to administer a PPD) Date: _____ Result_____

5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?

(a) Substance: OTC, non-prescription medication abuse or misuse
1. Recent (within the last 6 months) __Yes __No
2. History __Yes __No

(b) Abuse or misuse of prescription medication or herbal supplements
1. Currently __Yes __No
2. Recent (within the last 6 months) __Yes __No

(c) History of non-compliance with prescribed medication
1. Currently __Yes__ No
2. Recent (within the last 6 months) __Yes __No

(d) Describe misuse or abuse: _____
_____

Resident Name _____ Date Completed _____
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6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply): __orthostatic hypotension __osteoporosis __gait problem __impaired balance __confusion __Parkinsonism __foot deformity __pain __assistive devices __other (explain)
_____

7.* Skin condition(s). Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders.
_____
_____
_____

8.* Sensory impairments affecting functioning. (Check all that apply.)

(a) Hearing:
Left ear: __Adequate __Poor __Deaf __Uses corrective aid
Right ear: __Adequate __Poor __Deaf __Uses corrective aid

(b) Vision:

Left eye __Adequate __Poor __Uses corrective lenses __Blind
Right eye __Adequate __Poor __Uses corrective lenses __Blind

(c) Temperature Sensitivity: __Normal __Decreased sensation to: __Heat __Cold

9. Current Nutritional Status. Height ___inches/ cm Weight ___lbs/ kg.

(a) Any weight change (gain or loss) in the past 6 months? __Yes __No

(b) How much weight change? ___lbs/ kg. in the past months (check one) __Gain __Loss

(c) Monitoring necessary? (Check one.) __Yes __No

If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur:
_____
_____

(d) Is there evidence of malnutrition or risk for undernutrition? __Yes __No

(e)* Is there evidence of dehydration or a risk for dehydration? __Yes __No

(f) Monitoring of nutrition or hydration status necessary?__ Yes __No
If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur:
_____
_____

(g) Does the resident have medical or dental conditions affecting: (Check all that apply)
__Chewing __Swallowing __Eating __Pocketing food __Tube feeding

(h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets restricted):
_____
_____

(i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids):
_____

Resident Name _____ Date Completed _____
Date of Birth _____

(j) Is there a need for assistive devices with eating (If yes, check all that apply): __Yes __No
__Weighted spoon or built up fork __Plate guard __Special cup/glass

(k) Monitoring necessary? (Check one.)__ Yes __No
If items (g), (h), or (i) are checked, please explain how and at what frequency monitoring is to occur:
_____
_____

10.* Cognitive/Behavioral Status.

(a)* Is there evidence of dementia? (Check one.) __Yes __No

(b) Has the resident undergone an evaluation for dementia? __Yes __No

(c)* Diagnosis (cause(s) of dementia): __Alzheimer's Disease __Multi-infarct/Vascular __Parkinson's Disease __Other

(d) Mini-Mental Status Exam (if tested) Date _____ Score _____

(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" section to provide any relevant details.

Cognition

I. Disorientation __Never __Occasional __Regular __Continuous
II. Impaired recall (recent/distant events) __Never __Occasional__ Regular __Continuous
III. Impaired judgment __Never __Occasional__ Regular __Continuous
IV. Hallucinations __Never __Occasional__ Regular __Continuous
V. Delusions __Never __Occasional__ Regular __Continuous
Comments:

Communication

VI. Receptive/expressive aphasia __Never __Occasional__ Regular __Continuous

Mood and Emotions

VII. Anxiety __Never __Occasional__ Regular __Continuous
VIII. Depression __Never __Occasional__ Regular __Continuous

Behaviors

IX. Unsafe behaviors __Never __Occasional__ Regular __Continuous
X. Dangerous to self or others __Never __Occasional__ Regular __Continuous
XI. Agitation (Describe behaviors in comments section)__Never __Occasional__ Regular __Continuous
Comments:

(f) Health care decision-making capacity. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, indicate this resident's highest level of ability to make health care decisions.

__(a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining
treatments that require understanding the nature, probable consequences, burdens, and risks of proposed treatment).
__(b) Probably can make limited decisions that require simple understanding.
__(c) Probably can express agreement with decisions proposed by someone else.
__(d) Cannot effectively participate in any kind of health care decision-making.

Resident Name _____ Date Completed _____
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11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his/her own medications safely and appropriately.

__(a) Independently without assistance
__(b) Can do so with physical assistance, reminders, or supervision only
__(c) Need to have medications administered by someone else

_____ _____
Print Name and title Date

_____
Signature of Health Care Practitioner

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION
(please attach a separate form or fill in below)
Allergies (list all):
_____
_____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

12 (a) Medication(s). Including PRN, OTC, herbal, & dietary supplements. Include dosage route (p.o., etc.), frequency, duration (if limited).	12(b) All related diagnoses, problems, conditions. Please include all diagnoses that are currently being treated by this medication.	12(c) Treatments (include frequency & any instructions about when to notify the physician). Please link diagnosis, condition or problem as noted in prior sections.	12(d) Related testing or monitoring. Include frequency & any instructions to notify physician.

Prescriber's Name _____Date _____

Office Address _____

Phone _____