



**Government of the District of Columbia  
 Department of Health  
 Health Regulation And Licensing Administration  
 Child And Residential Care Facilities Division  
 Assisted Living Residence  
 Admission/Annual Medical Certification  
 (General and Special Permission Placement)**

825 North Capitol Street, NW  
 2nd Floor  
 Washington, DC 20002  
 202- 442-5888

**ALL SPACES MUST BE FILLED OUT**

I certify the Assistance Living Residence Placement of

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

Resident's Name: \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_  
 DD MM YYYY

Present Home Address: \_\_\_\_\_  
 Street  
 \_\_\_\_\_  
 City State Zip

**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: _____
<input type="checkbox"/> Yes - Date: _____	<input type="checkbox"/> Yes - Date: _____	<input type="checkbox"/> Yes - Date: _____	
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	

**Tuberculin Test\***

Yes TST1 \_\_\_\_\_ Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_ Mfr. \_\_\_\_\_ Lot # \_\_\_\_\_  
 \_\_\_\_\_ mm induration

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

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"/> Continual <input type="checkbox"/> <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"/> <input type="checkbox"/> With Supervision <input type="checkbox"/> With Assistance

**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? \_\_\_\_\_

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

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

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

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

**4. IMPAIRMENTS :**

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

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

**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 \_\_\_\_\_

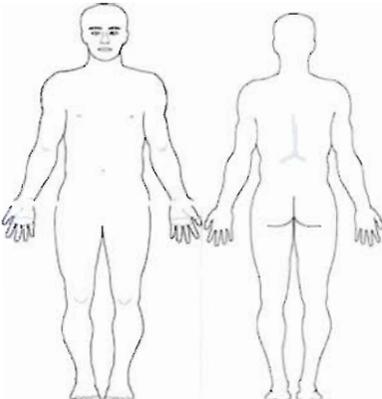
Does patient wear dentures?  No  Yes  Upper  Lower

**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

Treatment: \_\_\_\_\_  
\_\_\_\_\_

## 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 Screen (if known)	Score of Previous 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  
 Constant Direction  Others

## 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: \_\_\_\_\_  
\_\_\_\_\_

Note: the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE**

- Correctly read the label on a medication container
- Correctly ingest, inject or apply the medication
- Open the container
- Correctly interpret the label
- Correctly follow instructions as to route, time, dosage and frequency
- Measure or prepare medications, including mixing, shaking and filling syringes
- Safely store the medication

10. 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
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**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:

- IS  IS NOT medically suited for care in an adult home or EHP.
- 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.

**LEVEL OF CARE RECOMMENDATION:**

- ALR  Special Needs ALR ; Specify \_\_\_\_\_

Signature: \_\_\_\_\_  
Physician

Date \_\_\_\_\_