STATEMENT OF PURPOSE

Adult Residential Care Programs provide 24 hour residential care settings for dependent adults. They are not medical facilities. Persons in need of constant medical care and supervision should not be admitted or retained in an adult residential care facility because such a facility lacks the staff and expertise to provide needed services. Persons who, by reason of age and or physical and/or mental limitations, are in need of assistance with the basic activities of daily living, can be cared for in adult residential care settings.

The information solicited in this medical evaluation will assist you, the individual, and the operator of an adult residential care facility in determining the level of care needed to assure the health, safety and well-being of the individual. It will become part of the resident's record and subject to review by the New York State Department of Health, which is responsible for supervision of Adult Residential Care Programs.

DSS-3122 (Revised 12/79)

MEDICAL EVALUATION
(Resident)

NAME

ADDRESS

SEX	DATE OF BIRTH	EXAMINATION DATE
M F		

SECTION I: **MEDICAL HISTORY**

PRIMARY DIAGNOSIS

RECENT SURGERY (type of procedure and date)	RECENT ACUTE ILLNESS (type and date)
CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS	SPECIAL DIET (must select one of the following) ☐ REGULAR ☐ NO ADDED SALT ☐ CONSISTENT CARBOHYDRATES
WEIGHT (include opinion regarding overweight, etc.)	BLOOD PRESSURE
ACTIVITY RESTRICTIONS	WEIGHT BEARING (full, partial, none)

REQUIRED PERIODIC OR INTERMITTANT NURSING CARE, AND/OR MEDICAL EXAMINATIONS, DOCTORS' VISITS, OR SKILLED OBSERVATION OF SYMPTOMS:

LIST ALL ALLERGIES:

SECTION II: MEDICATIONS NEEDED

TYPE, FREQUENCY, AND DOSAGE: **If attaching a medication list; DoH requires a physician signature on every page.**

SECTION III: OBSERVATION OF INDIVIDUAL

yes	no	Is the individual capable of self-administration of Required medications?	yes	no	Bedfast – Unable to transfer
yes	no	Ambulatory – Without assistance	yes	no	Incontinent (describe)
yes	no	Ambulatory – With assistance	yes	no	Habituated or addicted to alcohol or other substance
yes	no	Chairfast – Able to transfer	yes	no	If yes, is the individual a danger to himself or others
yes	no	Chairfast – Unable to transfer	yes	no	Free of communicable disease
yes	no	Bedfast – Able to transfer			

SECTION IV:

In your opinion does the individual need the support and services available in and adult residential care setting? (please describe fully)

Does the individual require placement in a skilled nursing or health related facility? (give reasons)

PHYSICIANS SIGNATURE	DATE