PHYSICIAN'S REPORT FOR DISCHARGE AND PLACEMENT IN ASSISTED LIVING OR RESIDENTIAL GROUP HOMES

1. FACILITY INFORMATION (To be completed by the licensee/designee)

1.Name of Group Home/ALF			2. Telephone	
3. Address	City	State	Zip Code	
4. Licensee's Name	5. FAX	6.Facility License #	Exp. Date	

2. RESIDENT/PATIENT INFORMATION (To be completed by the resident/responsible person)

1. Name	2. Birth Date	3. Age

3. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(To be completed by the resident/responsible person)

I hereby authorize release of medical information in this report to the facility or persons requesting the documents.

1. Name of Resident and /or resident's legal representative and Signature (POA)

2. Address	Date:

4. PATIENT'S INFORMATION AND DIAGNOSIS

(To be completed by the Physician or PA or Discharge RN)

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the State of Nevada Department of Health and Human Services. The license requires the facility to provide primary **non-medical care and supervision** to meet the needs of that person. **THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE**. The information that you provide about this person is needed to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered to the best of your knowledge.

1. Date of Exam	**2.Sex**	**3. Height**	**4.Weight**	**5.Blood Pressure**
Vital Signs	**Temperature:**	**Pulse:**	**Respirations:**	

5. TUBERCULOSIS (TB) TEST State law requires a TB screening Please order HH to follow up

1.Date Step 1	**2. Date Step 1 Read**	**3. Results Step 1 Positive Negative ☐**	**1. Date Step 2**	**2. Date Step 2 Read**	**3. Results Step 2 Positive ☐ Negative ☐**
Results: mm			**Action Take if positive:**		

Blood test: QuantiFERON Date: Results:	***Chest X-ray if skin test is positive or patient refuses skin test only.*** **Results: Active TB ☐ Latent TB infection ☐ No Evidence of TB Infection ☐**

6. PRIMARY DIAGNOSIS:

What type of supervision is needed? Skilled ☐ Non-skilled ☐ = Assisted/Group Home)

7. SECONDARY DIAGNOSIS(ES):

What type of supervision is needed? Skilled ☐ Non-Skilled ☐ = Assisted/Group Home)

8. CHECK IF APPLICABLE TO DIAGNOSIS ABOVE:

Oriented to: Person ☐ Place ☐ Time ☐

☐ **MCI:** Mild Cognitive Impartment: Refers to people whose cognitive abilities are in a: conditional state" between normal and aging and dementia.

☐ **Dementia**: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgment and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities**. DCode: 331.2**

☐ **Alzheimers:** The significant loss of intellectual function (such as thinking, remembering, reasoning, exercising judgment and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities. **At risk for wandering and or displays sundowner behavior. This person requires a locked unit. DCode 331.0**

☐ **Mental Illness:** Bipolar disorder, psychosis, schizophrenia and other related disorders.

☐ **Chronic Illness**: suffers from chronic illness or progressively debilitation illness.

9. CONTAGIOUS/INFECTIOUS DISEASE							
YES ☐ **NO** ☐	**C-Diff**	**Yes** ☐	**Hep C**	**Yes** ☐	**Shingles**	**Yes** ☐
Clear Cultures Yes ☐ Please Attach **No** ☐	**MRSA**	**Yes** ☐	**VRE**	**Yes** ☐	**Scabies**	**Yes** ☐
	Lice	**Yes** ☐	**Herpes**	**Yes** ☐	**HIV**	**Yes** ☐

10. ALLERGIES:

SPECIAL DIET:

11. PHYSICAL HEALTH STATUS	**YES**	**NO**	**EXPLAIN**
a. Auditory Impairment			
b. Visual Impairment			
c. Wears Dentures			
d. Wears Prosthesis			
e. Special Diet			
f. Substance Abuse Problem			
g. Use of Alcohol			
h. Use of Cigarettes			
i. Bowel impairment			
j. Bladder impairment			(Catheter?) Y N
k. Motor Impairment/Paralysis			
l. Requires continuous bed care and turning			
m. History of skin condition or breakdown			
12. MENTAL CONDITION	**YES**	**NO**	**EXPLAIN**
a. Confused/Disoriented			
b. Inappropriate Behavior			
c. Aggressive/Combative Behavior			
d. Wandering Behavior			
e. Sundowning Behavior			
f. Able to follow instructions			
g. Depressed			
h. Suicidal/Self-Abuse			
i. Able to communicate needs			
j. At risk if direct access to personal grooming items			
k. Able to leave facility unassisted			

13. CAPACITY OF SELF CARE	YES	NO	EXPLAIN
a. Able to bathe self			
b. Able to dress/groom self			
c. Able to feed self			
d. Able to care for own toileting needs			
e. Able to manage own cash resources			
14. MEDICATION MANAGEMENT	**YES**	**NO**	
a. Able to administer own prescription medication			
b. Able to administer own glucose testing			
c. Able to administer own injections			
d. Able to administer own PRN medication			
e. Able to administer own Oxygen			
f. Able to store own medication			
g. **Patient is a Diabetic Type I requiring insulin**			
REFUSING MEDICATION			**Crush Order Yes ☐ No ☐**

One Person Assist ☐ Two Person Assist ☐ Contact Guard Assist ☐ Stand By Assist ☐

15. Category STATUS

Category 1 = NAC 449.1591. a resident who, without the assistance of any other person, is physically or mentally capable of moving himself from the room in which he sleeps to the outside of the facility in 4 minutes or less: or capable of moving himself to the other side of a smoke or fire barrier or outside the facility.

This person is Category 1 ☐ Check Box if this applies to resident

Category 2 = NAC 449.1595 , a resident who, without the assistance of any other person, **is not physically or mentally capable of moving himself** from the room in which he sleeps to the outside of the facility in 4 minutes or less.

This person is Category 2 ☐ Check Box if this applies to resident

Bedfast: Means either requiring assistance in turning and repositioning in bed, Residents requiring this type of assistance should be placed in a HIRC home or may be admitted to a Residential Group Home if on hospice.

This person is Bedfast ☐ check here

b. **If resident is Category 2, this status is based upon:**

Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition ☐

c. If resident is bedridden, check one or more of the following and describe the nature of the illness

☐ Illness: ☐ Recovery from Surgery: ☐ Other:

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist? Number of Days:

e. Is resident receiving Palliative Care? ☐ Is resident receiving Hospice Care? ☐

If yes, specify the terminal illness:

16. PHYSICAL HEALTH STATUS: Good ☐ Fair ☐ Poor ☐

17. Comments:

18. Attending Physicians Name:

19. ADDRESS:

20. TELEPHONE: **21. FAX:**

22. DATE: **23. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT:**

24. Physician, PA or discharge nurse SIGNATURE:

Please be aware that our clients may not be placed until this form is completed. We appreciate your cooperation and attention to this requirement. Please include page 4-medication list.

Admission to Residential Group Home or Assisted Living
Review or Admission Medication List

List current prescribed medications that are being taken by the resident on this form and include Vitamins and over the counter PRN **(Need prescriptions written separately, not an order sheet)**

PRINT Admission or Review Medication List	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
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22.	
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24.	
25.	
26.	

May generic medications be substituted for name brands? Yes No

PRINT PA or Physicians Name:	
ADDRESS:	
TELEPHONE:	**21. FAX:**
PA or PHYSICIANS SIGNATURE:	**Date:**