

**PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES****For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).****NOTE TO PHYSICIAN:**

The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

**THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.**

The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

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

NAME OF FACILITY:			TELEPHONE:
ADDRESS: NUMBER	STREET	CITY	
LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:	

**RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)**

NAME:			TELEPHONE:
ADDRESS: NUMBER	STREET	CITY	
NEXT OF KIN:	PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:		

**PATIENT'S DIAGNOSIS (To be completed by the physician)**

PRIMARY DIAGNOSIS:			
SECONDARY DIAGNOSIS:			LENGTH OF TIME UNDER YOUR CARE:
AGE:	HEIGHT:	SEX:	WEIGHT:
IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
TUBERCULOSIS EXAMINATION RESULTS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> NONE			DATE OF LAST TB TEST:
TYPE OF TB TEST USED:		TREATMENT/MEDICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES: A) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:	TREATMENT/MEDICATION: B) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:
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ALLERGIES C) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:	TREATMENT/MEDICATION: D) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:
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Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed:  Yes  No

2. For purposes of a fire clearance, this person is considered:

- Ambulatory  Nonambulatory  Bedridden

**Nonambulatory:** A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.

**Note:** A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

**Bedridden:** For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR		COMMENTS:			
		YES (Check One)	NO	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment					
2. Visual impairment					
3. Wears dentures					
4. Special diet					
5. Substance abuse problem					
6. Bowel impairment					
7. Bladder impairment					
8. Motor impairment					
9. Requires continuous bed care					
II. MENTAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR		COMMENTS:			
		NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused					
2. Able to follow instructions					
3. Depressed					
4. Able to communicate					
III. CAPACITY FOR SELF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO		COMMENTS:			
		YES (Check One)	NO	COMMENTS:	
1. Able to care for all personal needs					
2. Can administer and store own medications					
3. Needs constant medical supervision					
4. Currently taking prescribed medications					
5. Bathes self					
6. Dresses self					
7. Feeds self					
8. Cares for his/her own toilet needs					
9. Able to leave facility unassisted					
10. Able to ambulate without assistance					
11. Able to manage own cash resources					

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

**CONDITIONS**

- 1. Headache
- 2. Constipation
- 3. Diarrhea
- 4. Indigestion
- 5. Others (*specify condition*)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OVER-THE-COUNTER MEDICATION(S)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_

PHYSICIAN'S NAME AND ADDRESS:

TELEPHONE:

DATE:

PHYSICIAN'S SIGNATURE

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)**

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE

ADDRESS:

DATE: