Medical Evaluation
(To be completed by applicant's physician)

Statement of Purpose

Adult Residential Care Program 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 limitation, are in need of assistance with the basic activities of daily living can be cared for in adult residential care settings.

Section 1: Applicant's Name

Name	Date of Birth: _____ / _____ / _____
Address	Sex: ❑ M ❑ F

Section 2: Medical History

Past History:	Present Status/Special Diet Requirements:
Last PPD Test: Administered On: Date Read: Result: Chest X-Ray Needed: ❑ YES ❑ NO If YES, Date of Chest X-Ray: Result: MD Signature:	Allergies To: (List any known) ___ NONE KNOWN Medications ___ NONE Food ___ NONE Other ___ NONE Activity Restrictions ___ NONE

Examination Findings:

Height:		Weight:	Blood Pressure:	
Appearance:			Nutrition:	
Head:		Hair:	Eyes:	
Ears:		Nose:	Mouth:	
Neck:		Chest:	Lungs:	
Heart	Rate:	Rhythm:	Borders:	
	Sounds:	Murmurs:		
Abdomen	Viscera:	Masses:	Hernia:	
Genital Organs:		Rectal & Urological:	Continent:	
Skeletal:		Mobility:	Deformities:	
Vascular:		Veins:	Arteries:	
Skin:			Tumors:	Nodes:
Neurological	Tremors:	Paralyses:	Other:	

Section 3: Medication (Type, Frequency and Dosage)

List all current medications (prescription and OTC) and note special instruction:

Section 4: Observation of Individual

Is Individual: (Please check either YES or NO)	YES	NO	DESCRIBE AS NEEDED
Ambulatory?			
Capable of self-administration of medication?			
Habituated to drugs?			
Habituated to alcohol?			
Danger to self or others?			
Free of communicable disease?			
Incontinent?			

Section 5: Evaluation

In your opinion can the individual's needs be met by the support services available in an adult care facility?

❑ YES ❑ NO (Please describe)

Does the individual have a relevant history, current condition or recent hospitalization for mental illness?

❑ YES ❑ NO (Please describe)

If YES to the above question, does the individual require a mental health evaluation? ❑ YES ❑ NO

PHYSICIAN'S SIGNATURE	DATE OF EXAMINATION	FORM COMPLETED
	_____ / _____ / _____	_____ / _____ / _____
PHYSICIAN'S NAME (PLEASE PRINT)	ADDRESS	PHONE NUMBER