REPORT OF RESIDENT PHYSICAL EXAMINATION

(Examination is to be completed by an independent physician within 30 days preceding the person's admission to the assisted living facility. Report of the examination is to be kept at the facility as part of the resident's record.)

NAME OF PERSON EXAMINED: _____ **DATE OF EXAMINATION:** _____

ADDRESS: _____

TELEPHONE: _____

Height: _____ **Weight:** _____ **BP:** _____

Significant Medical History:

General physical condition, including systems review as is medically indicated:

Allergies (food, medicine, or other) and description of the person's reactions:

Is this person:

_____ **Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such person may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate).**

_____ **Nonambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).**

Person's Name _____

Is this person capable of self-administering medication? _____ **Yes** _____ **No**

Does this individual have any of the following conditions or care needs?

Condition/Care Need	Yes	No	Comment
Ventilator dependency			
Dermal ulcers III and IV			If stage III, is ulcer healing?
Intravenous therapy or injections directly into the vein			If intermittent therapy, please note and indicate expected time period.
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission			
Psychotropic medications without appropriate diagnosis and treatment plans			
Nasogastric tubes			
Gastric tubes			If yes, is person capable of independently feeding himself and caring for the tube?
Presents imminent physical threat or danger to self or others			
Requires continuous licensed nursing care			

Person's Name _____

Diagnosis or significant problems:

_____

_____

_____

_____

_____

_____

Recommendations for care:

Medications: _____

_____

_____

_____

Diet: _____

_____

_____

Therapy: _____

_____

_____

_____

Other: _____

_____

_____

Screening for Tuberculosis:
Results of a risk assessment documenting the absence of tuberculosis in a communicable form as evidence by the completion of the current screening form published by the Virginia Department of Health or a form consistent with it. A Report of TB Screening form, which may be used, is attached.

Name of Physician: (print) _____

Name of Designee, if applicable: (print) _____

Signature of Physician or Designee: _____ **Date:** _____

Address: (Street, City, State, Zip Code) _____

Telephone: _____

ATTACHMENT

REPORT OF TB SCREENING

Name: _____ Date of Birth: _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility/practice)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ A tuberculin skin test (PPD) was administered on _____ and results, read on _____, were as follows:

_____ mm _____ Negative _____ Positive.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)

Print Name/Title: _____ Phone: _____

Address: _____

_____

_____