



RESIDENT HISTORY AND PHYSICAL FORM

REPORT OF RESIDENT'S PHYSICAL EXAM – (to be completed by resident's physician within 30 days prior to date of acceptance for admission. Report to be part of resident's permanent record.)

Name Address

Telephone Number

1. **Date of Physical Examination:** _____ **Place of Examination:** _____
Office _____ Hospital _____ Other _____
(specify hospital) _____

BP _____ TEMP _____ PULSE _____ RSP _____

DIAGNOSIS/SIGNIFICANT:

Primary: _____
Contributory: _____
Secondary: _____
Present level of cognitive functioning: _____

GENERAL APPEARANCE:

EENT: _____
Neck: _____
Chest: _____
Heart: _____
Abdomen: _____
Extremities: _____
Skin: _____
Pelvic: _____
Rectal: _____
Height: _____ Weight: _____

HISTORY OF ILLNESSES:

Diabetes _____ Seizures _____ Dizziness _____ Arthritis _____
CVA _____ Heart Disease _____ Cancer _____ Allergy _____
TB _____ Kidney Disease _____ Other _____

PLEASE LIST ANY PREVIOUS HOSPITALIZATIONS FOR INJURY, SURGERY, ILLNESSES, ETC: _____

PLEASE LIST ALL KNOWN ALLERGIES (Medicine, Food, etc.):

2. (A) Date of screening for TUBERCULOSIS according to accepted methods of VA Department of Health: _____
(B) Type of test: _____
(C) Test results: _____

Standards permit the initial screening for TB to be tuberculin skin test. Each person, whose physician certifies the absence of TB in a communicable form, even though the test is positive, must obtain a chest x-ray on an annual basis for the following two (2) years.

- (D) This person is _____, is not _____ free of TB in a communicable form.
(E) If it is medically inappropriate for this person to have a TB test, please check.

The patient must be tested for TB no more than 30 days prior to admission to the facility.

3. **RECOMMENDATIONS FOR CARE:**

- (A) Diet (choose one):
regular _____ no salt added _____ no concentrated sweets _____
(B) Specific treatments/therapy: _____

(C) Medications: _____

(D) Mental Condition:
Hospitalization for mental illness: _____

If so, what type: _____

When & how many times: _____

Results? _____

Any h/o aggressive behavior or dangerously agitated states? _____

Senility: Slight _____ Moderate _____ Advanced _____

H/O drug addiction or excessive ETOH intake? _____

Mental Health After Care/Follow Along Service Requirements if Appropriate:
(completion required for persons being discharged from a State Program for the Mentally Ill or Mentally Retarded). _____

(E) Other: _____

Amerisist is licensed by the Department of Social Services, Commonwealth of Virginia, in accordance with Section 22 VAC 40-71-150 of the Standards and Regulations for Licensed Adult Care Residence, no person who is in need of skilled nursing care shall be admitted.

1. In your opinion, does this individual need skilled nursing care? Yes ___ No ___
2. In your opinion, can this individual's needs be met in an Adult Care Residence?
Yes _____ No _____
3. In your opinion, is this individual bedfast (confined or restricted to bed for prolonged or indefinite periods)? Yes _____ No _____
4. Does this person need any type of restraint to provide physical support because of a weakened condition? Yes _____ No _____
5. Is this person capable of administering his/her own medication without assistance? Yes _____ No _____
6. (A) In your opinion, is this individual physically and mentally capable of self preservation by evacuating to an emergency refuge area without the assistance from another person, or from the facility itself without the assistance of another person, even if the individual may require the assistance of a wheelchair, walker, cane, prosthetic device or a single verbal command to evacuate? Yes _____ No _____

(B) In your opinion, does this person have the sensory and mental ability to perceive an emergency and make an exit from the building, including ascent or descent of stairs, without the assistance of another person? 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			
Intravenous therapy or injections directly into the vein			
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission			

Condition/Care Need YES NO Comment _____

Psychotropic medication
Without appropriate diagnosis
& treatment plans

Nasogastric tubes

Gastric tube

If yes, is person capable of
independently feeding
himself & caring for tube?

Presents imminent
physical threat or
danger to self or
others

Requires continuous
licensed nursing care

Comments: _____

Physician's signature

Date: _____

Please print or type Physician's name, address & telephone number here:

Name: _____

Address: _____

Phone #: _____