ORCHARD HEIGHTS, INC.
5200 CHESTNUT RIDGE ROAD
ORCHARD PARK, NY 14127
716-662-0651

Guidelines for Completion of DOH 3122
Medical Evaluation 25.103(1)

1. **Please place an answer in every category. (None or Not Applicable is accepted. Blanks are not accepted.)**
2. All information must be completed (Personal). This includes the complete address and date of birth.
3. The examination date must be within 30 days of the resident's admission.
4. All medications (including non-prescription drugs) must indicate route, time and dosage.
5. **Please include prescriptions for all medications listed.**
6. An order must be written for a resident to have bed rails, hospital bed, walker, wheelchair, scooter, O^2, urinals, commodes, etc.
7. Alcoholic Beverage orders: Must be specific to when allowed and maximum beverages included or allowed for consumption.
8. **Please print or type the Physician's name under the Signature. The date of the examination must be written. If completed by a Nurse Practitioner, the physician must co-sign his/her signature. Stamped signatures cannot be accepted.**
9. **If attaching a medication list, must be signed and dated by the Physician.**

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Resident's Name:______________________________ **Date of Exam:**__________

Facility Name:__________________ Date of Birth:__________ Sex:__________

Present Home Address:____
Street City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in condition | ☐ Other:__________

MEDICAL REVIEW FINDINGS

Vital Signs: BP:_____ Pulse:_____ Resp:_____ T:_________ Height:____ ft _____in. Weight:_______

Primary Diagnosis(s): ____

____

Secondary Diagnosis(s): ____

Allergies: ☐ **None** or list **Known Allergies:** ____________________________

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Other: ____________________

Immunizations ☐ Influenza (Date_______________) ☐ Pneumococcal Vaccine (Date_______________)

TB SCREENING *(performed* ***within 30 days prior to initial admission*** *unless medically contraindicated)*

☐ **Test is contraindicated** **Test:** ☐ TST1 ☐ TST2 ☐ TB Blood Test (Type)__________ Date__________ Result__________

TST1: Date placed _______ Date Read _______ mm _______ TST2: Date placed _______ Date Read _______ mm _______

Based on my findings and on my knowledge of this patient, I find that the patient _______ **IS** _______ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management: ____

LABORATORY SERVICES: ☐ None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency

New York State Department of Health

Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: ______________________ **Date:** __________

ACTIVITIES OF DAILY LIVING (ADL's

Activity Restrictions: No ☐ Yes ☐ (describe): ______________________

Dependent on Medical Equipment: No ☐ Yes ☐ (describe): ______________________

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1. Ambulate: Independent ☐ Intermittent ☐ Continual ☐
2. Transfer: Independent ☐ Intermittent ☐ Continual ☐
3. Feeding: Independent ☐ Intermittent ☐ Continual ☐
4. Manage Medical Equipment: Manages Independently ☐ Cannot Manage Independently ☐

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up: None ☐ or if yes, describe ______________________

____

Therapies: ☐ None ☐ Yes (specify): ☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy

Home Care: ☐ None ☐ Yes (specify): ______________ Other (Specify): ______________

Is Palliative Care Appropriate/Recommended: ☐ No ☐ If yes, describe services: ______________

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? ☐ No ☐ Yes

If yes, do you recommend testing be performed? ☐ No ☐ If yes, referral to: ______________

If testing has already been performed, date/place of testing if known: ______________

MENTAL HEALTH ASSESSMENT (non-dementia)

Does the patient have a history of or a current mental disability? ☐ No ☐ Yes

Has the patient ever been hospitalized for a mental health condition? ☐ No ☐ Yes

If yes, describe: ______________________

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)

☐ No ☐ Yes Describe: ______________________

MEDICATIONS

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- Correctly read the label on a medication container
- Correctly ingest, inject or apply the medication
- Open the container
- Safely store the medication
- Correctly follow instructions as the route, time dosage and frequency
- Measure or prepare medications, including mixing, shaking and filling syringes
- Correctly interpret the label

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ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name:______________________________ **Date:**__________________

Resident will receive assistance with all medications unless physician indicates that resident is capable of self-administration.

1. Does the patient/resident require assistance with medications (see criteria on page 2)? Yes ☐ No ☐
2. List all prescription, OTC medications, supplements and vitamins. Attach additional sheets if necessary or attach current discharge note, signed by the physician, listing ALL medications.

Medication	Dosage	Type	Frequency	Route	Diagnosis/Indication	Prescriber (name of MD/NP)

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR):

- provide 24-hour residential care for dependent adults
- are not medical facilities
- are not appropriate for persons in need of constant medical care and medical supervision and these persons should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services.
- Persons who, by reason of age and/or physical and/or mental limitations who are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above, or if applicable, an EALR OR SNALR.

PHYSICIAN CERTIFICATION

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

☐ Yes ☐ No Is mentally **suited** for care in an Adult Home/Enriched Housing Program/Assisted Living Residence / Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ Yes ☐ No Is medically **suited** for care in an Adult Home or Enriched Housing Program/Assisted Living Residence / Enhanced Assisted Living Residence (EALR/Special Needs Assisted Living Residence (SNALR).

☐ Yes ☐ No **Is not** in need of continual acute or long term medical or nursing care, including 24-hour skilled nursing care or supervision, which would require placement in a hospital or nursing home.

Name/Title of individual completing form:______________________________ **Date:**__________________

Physician Signature:______________________________ **Date:**__________________

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Resident Name: ______________________________ Date: _________

PRN Medications

___ Tylenol (325mg-2 tabs-po q 4 h prn pain/ elevated temp

___ K-Peck 30cc po q 4 h prn diarrhea

___ Robitussin 15cc po q 4 h prn cough

___ Maalox 30cc po q 4 h prn indigestion

___ MOM 30cc po qd prn constipation

Does the patient have the ability to identify the need for the prescribed medications? _____ Yes _____ No

Additional Medications

___**None**

Resident can self manage the following devices

___ 1/2 Side Rail for positioning

___ Walker

___ Shower Chair

___ Oxygen (Please describe order)___________________

___ W/C (Can Self Propel)

___ Elevated Toilet Seat

___ Cane

___ May receive flu vaccine annually

___ May be served alcoholic beverages at activities with a Two (2) 4-ounce Drink Maximum

___ May Participate in Activities and Exercise Program

PMD Signature____ Date_________________