

INSTRUCTIONS FOR COMPLETING RESIDENT MEDICAL EVALUATION

NOTE: THE RESIDENT MEDICAL EVALUATION IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE INDIVIDUAL

In the top left-hand box, indicate if this is a **NEW** or an **UPDATED** resident medical evaluation.

APPLICANT INFORMATION:

Questions 1 through 6 are self-explanatory.

7. **Physician's Signature.** A licensed physician must sign and date the resident medical evaluation. It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT]).
9. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.
10. **Essential Vital Signs.** Self-explanatory – complete all sections.
11. **Medical History.** Include any medical information pertinent for determination of the individual's services. Attach a separate sheet if additional documentation is necessary.
12. **Diagnoses.** List all conditions that the individual has been diagnosed as having.
13. **Communicable Disease.** Indicate the most current up-to-date information. Is the individual free of communicable disease?
14. **Immunizations.** Are the immunizations up-to-date for this individual? List the individual's immunization history. Examples include: Tetanus/Diphtheria/Acellular Pertussia (Td/Tdap), Influenza, and other immunizations. Attach a separate sheet if necessary. If the individual's medical history is unknown, please check the "unknown" box provided.
15. **Allergies.** List the individual's known allergy history. Attach a separate sheet if necessary. If the individual's allergy history is unknown, please check the "unknown" box provided. If the individual has no known allergies, please check the "none" box provided.
16. **Emergency Evacuation.** Indicate the type of assistance the individual requires to evacuate the building in an emergency. Check all applicable.
17. **Medication Administration.** Is the individual capable of administering his/her own medications? Check all applicable.
18. **Recommendation for Appropriate Level of Care.** Physician must recommend individual's level of care.
19. **Physician Orders.** Medications should have diagnoses to support their use. Please complete all sections. If the individual has no special needs, please check the "none" box provided.

**ADULT RESIDENTIAL LICENSING – PERSONAL CARE HOMES
RESIDENT MEDICAL EVALUATION - 55 Pa.Code § 2600.141**

(To be completed within 60 days prior to admission or within 30 days after admission)

Required for ALL residents. For residents who receive SSI a MA-51 medical evaluation form is also required.

<input type="checkbox"/> NEW	1. NAME OF APPLICANT	2. SOCIAL SECURITY NUMBER	3. BIRTHDATE	4. AGE	5. SEX
<input type="checkbox"/> UPDATED					
6. PHYSICIAN NAME (Printed)		7. PHYSICIAN SIGNATURE		8. DATE	9. PHYSICIAN LICENSE NUMBER
10. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	
11. MEDICAL HISTORY: (Attach a signed and dated separate sheet if additional documentation is necessary)					
12. DIAGNOSES:					
13. COMMUNICABLE DISEASE: Is the individual free of Communicable Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
14. IMMUNIZATIONS: Are immunizations up-to-date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Tetanus / Diphtheria / Acellular Pertussis (Td/Tdap) (every 10 years) Date: _____					
Influenza (every year) Date: _____ Other – List Immunization & Date: _____					
15. ALLERGIES - List known allergies: (Attach a signed and dated separate sheet if additional documentation is necessary) <input type="checkbox"/> NONE <input type="checkbox"/> UNKNOWN					
16. EMERGENCY EVACUATION - Mobility Needs: In the event of an emergency, how much assistance does the applicant require to vacate the building? (Check All Applicable)			18. RECOMMENDATION FOR APPROPRIATE LEVEL OF CARE:		
<input type="checkbox"/> Unable to move from one location to another without physical assistance from others <input type="checkbox"/> Unable to move from one location to another without oral prompting from others <input type="checkbox"/> Difficulty understanding and following oral directions in the event of an emergency <input type="checkbox"/> Independently mobile with ambulation device. Specify device used: _____ <input type="checkbox"/> Walks without assistance			<input type="checkbox"/> Nursing Care <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Independent Living without supports <input type="checkbox"/> Independent Living with in-home supports <input type="checkbox"/> Specialized Care (Specify Type: _____ _____)		
17. MEDICATION ADMINISTRATION – Self-Administer Medications: Is the applicant capable of administering his/her own medications? (Check All Applicable)					
<input type="checkbox"/> Can self-administer medications with no assistance from others <input type="checkbox"/> Can self-administer medications with assistance to store medications in a secure place <input type="checkbox"/> Can self-administer medications with assistance in remembering schedule <input type="checkbox"/> Can self-administer medications with assistance in offering medications at prescribed times <input type="checkbox"/> Can self-administer medications with assistance in opening container or locked storage area OR (Check) <input type="checkbox"/> Cannot self-administer medications					
19. PHYSICIAN ORDERS (Record as "NONE" if there are no special needs related to the following):					
Medications <input type="checkbox"/> NONE _____					

Treatment/Therapies <input type="checkbox"/> NONE _____					

Diet <input type="checkbox"/> NO SPECIAL DIET _____					
Activities/Social Services _____					
Body Positioning <input type="checkbox"/> N/A _____					