OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION

PRE-ADMISSION/ANNUAL SCREENING FORM

RESIDENTIAL BOARD AND CARE HOME/PERSONAL CARE HOME
RESIDENTIAL CARE COMMUNITY

A. DEMOGRAPHIC/SOCIAL INFORMATION

1. Individual's Full Name: ____________________________________________________________

2. Sex:  □ Male    □ Female

3. Address (Including Street/Box, City, State & Zip Code): ____________________________________________

4. County: ________________________________________________________________

5. Social Security Number: ________________________________

6. SSI Recipient:  □ Yes    □ No

7. Birth Date (Include Month/Date/Year): ________________________________

8. Age: ________________________________________________________________

9. Name, Address & Phone Number of Spouse, Legal Representative or Emergency Contact: ____________________________

10. Admitted From: □ Hospital    □ SNF    □ NF    □ ICF/MR    □ Personal Care Home
       □ Residential Board & Care Home    □ Adult Family Care
       □ Own Home/Apartment    □ Home of Relative    □ State Facility
       □ Assisted Living    □ Other ________________________________

Name and Address ________________________________________________________________

11. Name, Address, Telephone Number of Physician, Dentist or other pertinent medical personnel ____________________________

12. Check if applicant has any of the following:

   □ Guardian       □ Committee       □ Medical Power of Attorney       □ Power of Attorney
   □ Durable Power of Attorney       □ Living Will       □ Resuscitation Directives
13. Occupation: __________________________________________

14. Hobbies or Leisure Time Interests: ______________________________

15. Religious Preference: ________________________________

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**B. MEDICAL/FUNCTIONAL STATUS**

1. Diagnosis/Pertinent History/Allergies: ______________________________

2. Medical Conditions/Symptoms Requiring Services: ______________________________

3. Decubitus:  ○ Yes  ○ No  If yes, check the following information:

   Stage: _______  Size: _______  Treatment: ______________________________

   Extremities:  ○ Left Leg  ○ Left Arm  ○ Right Leg  ○ Right Arm  ○ Left Hip  ○ Right Hip
   ○ Left Buttock  ○ Right Buttock  ○ Other ______________________________

   Developed At:  ○ Home  ○ Hospital  ○ Facility  ○ Other ______________________________

4. Professional and Technical Care Needs - Check All That Apply:

   ○ Physical Therapy   ○ Speech Therapy   ○ Occupational Therapy   ○ Inhalation Therapy
   ○ Continuous Oxygen   ○ Suctioning   ○ Tracheostomy   ○ Ventilator   ○ Dialysis   ○ Parenteral Fluids

   ○ Special Dressings   ○ Irrigations   ○ Special Skin Care   ○ Other ______________________________

5. Individual is Capable of Administering His/Her Own Medications:  ○ Yes  ○ No

   * Self Administration is defined as: Resident can Independantly read and understand medication labels.

6. Diet Order: __________  Height: __________  Weight: __________

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7. Current Medication and Treatment Orders (including over the counter medications):


8. Activity Restrictions:


9. Tuberculosis Screening: Date __________ Results ________________________________

Previous Positive Result __________ Presence of Symptoms __________ Absence of Symptoms ___________

10. In the event of an emergency, the individual can vacate the building (RCC and RBC only):

☐ Independantly  ☐ Requires Verbal Prompting  ☐ Physically/Mentally Unable to Self Preserve

Services required by this resident can be met in a:

- Residential board and care home  ☐ Yes  ☐ No
- Personal care home  ☐ Yes  ☐ No
- Residential care community  ☐ Yes  ☐ No

Comments/Explanations: ____________________________________________

11. Resident is in need of sleep time supervision by awake staff.  ☐ Yes  ☐ No

Comments/Explanations: ____________________________________________

12. Functional Level - Indicate functional level number in left column using the following two determining factors: Occasional (Less than three times a week) or Frequent (more than three times a week).

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<tr>
<th>ITEM</th>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
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<tbody>
<tr>
<td>Eating</td>
<td>Self</td>
<td>With Assistance</td>
<td>Total Care</td>
<td>Tube Fed</td>
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<tr>
<td>Bathing</td>
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<td></td>
</tr>
<tr>
<td>Dressing</td>
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<td></td>
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<tr>
<td>Cont./Urine</td>
<td>Continent</td>
<td>Occas. Incontinent</td>
<td>Incontinent</td>
<td>Catheter</td>
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<td>Cont./Bowel</td>
<td>Continent</td>
<td>Occas. Incontinent</td>
<td>Incontinent</td>
<td>Colostomy</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Clear</td>
<td>Occas. Confused</td>
<td>Confused</td>
<td>Semi-comatose</td>
</tr>
<tr>
<td>Noisy</td>
<td>Never</td>
<td>Occasionally</td>
<td>Frequently</td>
<td>Comatose (5)</td>
</tr>
</tbody>
</table>
13. Clinical and psychosocial data: Please check any of the following behavior(s) which the individual has exhibited in the last two years.

- [ ] Combative
- [ ] Seriously Impaired Judgement
- [ ] Withdrawn/Depressed
- [ ] Suicidal Thoughts, Ideation/Gestures
- [ ] Hallucinates
- [ ] Cannot Communicate Basic Needs
- [ ] Delusional
- [ ] Talks About His/Her Worthlessness
- [ ] Disoriented
- [ ] Unable To Understand Simple Commands
- [ ] Bizarre Behavior
- [ ] Experiences Difficulty Learning New Skills
- [ ] Bangs Head
- [ ] Dangerous To Self/Others
- [ ] Sets Fires
- [ ] Demonstrates Severe Maladaptive Behaviors
- [ ] Displays Inappropriate Social Behavior
- [ ] Specialized Training Needs

Does the individual have Alzheimer's, Multi-Infarct, Senile Dementia, or Related Condition?  [ ] Yes  [ ] No
Other (Specify) ____________________________________________________________

Has the individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness?  [ ] Yes  [ ] No

If yes, specify agency:

Name ____________________________ Address ________________________________

Admission Date _________________ Discharge Date ____________________________

**PHYSICIAN’S SIGNATURE**

To the best of my knowledge, the patient's medical needs and related needs are essentially as indicated above.

Physician's Signature

Date of Assessment

Type or Print Physician's Name, Address & Phone Number

______________________________________________
______________________________________________
______________________________________________