PREPLACEMENT APPRAISAL INFORMATION

Admission - Residential Care Facilities

NOTE: *This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).*

APPLICANT NAME:	AGE:

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS

☐ OUT OF BED ALL DAY ☐ IN BED ALL OR MOST OF THE TIME ☐ IN BED PART OF THE TIME	COMMENT:

TUBERCULOSIS INFORMATION

ANY HISYORY OF TUBERCULOSIS IN APPLICANTS FAMILY? ☐ YES ☐ NO	DATE OF TB TEST:	☐ POSITIVE ☐ NEGATIVE
ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? ☐ YES ☐ NO	ACTION TAKEN (IF POSITIVE)	

GIVE DETAILS:

AMBULATORY STATUS (this person is ☐ ambulatory ☐ nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
☐	☐	Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
☐	☐	Mentally and physically able to follow signals and instructions for evacuation.
☐	☐	Able to use evacuation routes including stairs if necessary.
☐	☐	Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO			
☐	☐	Active, requires no personal help of any kind - able to go up and down stairs easily		
☐	☐	Active, but has difficulty climbing or descending stairs		
☐	☐	Uses brace or crutch		
☐	☐	Feeble or slow		
☐	☐	Uses walker. If Yes, can get in and out unassisted?	☐ Yes	☐ No
☐	☐	Uses wheelchair. If Yes, can get in and out unassisted?	☐ Yes	☐ No
☐	☐	Requires grab bars in bathroom		
☐	☐	Other: (Describe)		

SERVICES NEEDED (Check items and explain)

YES	NO	
☐	☐	Help in transferring in and out of bed and dressing
☐	☐	Help with bathing, hair care, personal hygiene
☐	☐	Does client desire and is client capable of doing own personal laundry and other household tasks (specify)
☐	☐	Help with moving about the facility
☐	☐	Help with eating (need for adaptive devices or assistance from another person)
☐	☐	Special diet/observation of food intake
☐	☐	Toileting, including assistance equipment, or assistance of another person
☐	☐	Continence, bowel or bladder control. Are assistive devices such as a catheter required?

☐ ☐ Help with medication

☐ ☐ Needs special observation/night supervision (due to confusion, forgetfulness, wandering)

☐ ☐ Help in managing own cash resources

☐ ☐ Help in participating in activity programs

☐ ☐ Special medical attention

☐ ☐ Assistance in incidental health and medical care

☐ ☐ Other “Services Needed” not identified above

Is there any additional information which would assist the facility in determining applicant’s suitability for admission? ☐ Yes ☐ No

If Yes, please attach comments on separate sheet.

To the best of my knowledge; I (the above person) do not need skilled nursing care.	
SIGNATURE	DATE COMPLETED
APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE COMPLETED
LICENSEE OR DESIGNATED REPRESENTATIVE	DATE COMPLETED