

MEDICAL EVALUATION *(page 2)*

NAME: _____

Is the individual:

Free of communicable disease? Yes No. If no, describe: _____

Able to transfer without assistance? Yes No. If no, describe: _____

Ambulatory without assistance? Yes No. If no, describe: _____

Describe Activity Restrictions/Assistance Needed with ADLs (e.g. eating, transferring, toileting):

Describe Current Treatment Plan (e.g., nursing, therapies, labs, etc.):

Is the individual's condition stable? Yes No. If no, describe: _____

Does the individual have a history, current condition or recent or current hospitalization for mental disability?

Yes No. If yes, describe: _____

Is a Mental Health Evaluation recommended? Yes No

Date of Today's Examination: _____ Recommended Frequency of Medical Exams: _____

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared in an adult home, enriched housing program or an ALP.

Signature: _____ Date: _____

Nurse Practitioner, Physician's or Specialist's Assistant

Signature: _____ Date: _____

Physician (required)