Greenview Living

4204 Ridgewood Road
Copley, Ohio 44321
Phone 330-819-1150
Fax 330-576-6358

To accelerate your acceptance approval into our home, please have this form filled out by the Resident's health care Provider and return to us as soon as possible.

Initial Health Assessment

Resident's Name _____ Age _____ Sex _____

Facility Name _____

These components may be performed by different health professionals, consistent with the type of information required and the professionals' scope of practice, as defined by applicable law. If different health professionals are used, each professional must sign the section they complete. If a physician is completing the entire assessment, he/she needs to only sign at the end of the form.

Health History: _____

_____

Does the Resident have a urinary tract infection?_____

Physical:

Height: _____ Weight: _____ BP: _____ Temp: _____ P: _____ R: _____

Lungs: _____ Heart: _____

Medical Diagnosis: _____

_____

Psychological Diagnosis: _____

_____

Medications – (Route and Frequency) List all current medications:

Allergies:

_____

_____

_____

Food Allergies:

_____

_____

_____

Dietary Requirements: _____

_____

_____

No Added Salt _____

Personal Care Services Required – Check all assistance required:

_____ Bathing _____ Dressing _____ Grooming _____ Ambulating

_____ Walking _____ Toileting _____ Feeding _____ Oral Hygiene

Mantoux Test Initial: (TB Test)

1st Step Given: _____ 2nd Step Given: _____

Date Read _____ Date Read: _____

Negative? ____No ____Yes Negative? ____No _____Yes

Capability for Medication Administration

To the Physician: Section 3722.011 of the Ohio Revised Code and Rule 3701-20-17 of the Administration Code requires that residents who live in adult care facilities be evaluated for their ability to self-administer medication with or without limited assistance. Please mark all statements that apply:

_____ No assistance needed.
_____ Needs assistance to open container and is able to request assistance.
_____ Needs reminders when to take medication.
_____ Needs watching to ensure resident follows directions on the container.
_____ Needs staff to take medications from locked storage and hand it to the resident.
_____ Needs staff to read label and directions upon request.
_____ Needs staff member to remind resident and any other individual designated by the Resident when prescribed medicine needs to be refilled.
_____ Is physically impaired but mentally alert and therefore:
  _____ Needs assistance in removing oral or topical as used in this paragraph (c) (3) of rule 3701-20-17 of the administrative code "topical medications" means a medication other than a deriding agent used in treatment of a skin condition or minor abrasion, and eye, nose, or ear drops excluding irrigations (upon resident request).
  _____ Needs staff member to place dose of medication in his or her mouth.

Physician's Signature _____ Date _____

Physician's Name _____

Address: _____

City/State/Zip _____ Phone _____