

## 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'S 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(Specify extent of any symptoms of confusion, forgetfulness; participation in social activities (i.e., active or withdrawn))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 HISTORY OF TUBERCULOSIS IN APPLICANT'S 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