## **Ohio Mental Health and Addiction Services**

Initial Health Assessment OAC <u>5122-33-18</u>

|   |   |  |  | Date:                |                      |
|---|---|--|--|----------------------|----------------------|
| Resident Name:                          |   |  |  | Age:                 | ☐ Male ☐ Female      |
| Facility Name:                          |   |  |  | License No.:         |                      |
| the professionals's must sign the secti | s may be performed by<br>cope of practice, as def<br>on they complete. If a<br>n additional form, or ad | ined by applicable la<br>physician is completi | w. If different health p<br>ng the entire assessme | rofessionals are use | d, each professional |
| Physical:                               |   |  |  |                      |                      |
| Height:                                 | BP:   |  | Lungs:   | P:                   |                      |
| Weight:                                 | Tem   | p:   | Heart:   | R:                   |                      |
| Health History:                         |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
| Medical Diagnos                         | is:   |  |  |                      |                      |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
| Psychological Dia                       | agnosis:  |  |  |                      |                      |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
| List of all current                     | Medication(s)   | Frequency                                      | List of all current M                              | ledication(s)        | Frequency            |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
| Dietary Requiren                        | nent(s):  |  |  |                      |                      |
|   |   |  |  |                      |                      |
|   |   |  |  |                      |                      |
| Dietary Requiren                        | nent(s):  |  |  |                      |                      |

| Resident Name:  |                         |  |                     |                        |                         |
|---|-------------------------|--|---------------------|------------------------|-------------------------|
| Allergies:  |                         | Food Allergies:  |                     | Other:                 |                         |
|   |                         |  |                     |                        |                         |
|   |                         |  |                     |                        |                         |
|   |                         |  |                     |                        |                         |
| Type of care of se  | rvice(s) requiring ass  | sistance or prompting  | :                   |                        |                         |
| ■ Walking   | ☐ Bathing               | ☐ Toileting  | Oral Hygien         | e 🔲 Other              |                         |
| Ambulating  | Dressing                | Feeding  | ☐ Grooming          | Other                  |                         |
| Which test was gi   | ven:                    |  |                     |                        |                         |
| ○ Mantoux 1   | st Step Given:          | Date Read:   | ○ Mantoux           | 2nd Step Given:        | Date Read:              |
| ○ X-ray   |                         |  | ○ X-ray             |                        |                         |
| Was the test Negative? Yes No Was the test Negative? Yes No |                         |  |                     |                        | No                      |
| Capability for Me   | dication Administrat    | tion:  |                     |                        |                         |
| be evaluated for t  |                         | i-18 of the Administrati<br>ninister medications w<br>apply:                   |                     |                        |                         |
| No assistance r   | needed. Nee             | ds staff to read label ar  | nd directions upor  | n request.             |                         |
| ■ Needs assistan  | ce to open container a  | and is able to request a   | ssistance. 🔲 N      | leeds reminders wher   | n to take medication.   |
| Needs watchin   | g to ensure resident fo | ollows directions on the   | e container.        |                        |                         |
| ☐ Needs staff to t  | ake medications from    | locked storage and ha  | nd it to the reside | nt.                    |                         |
| Needs staff me<br>to be refilled.                           | ember to remind resid   | lent and any other indi  | vidual designated   | by the resident when   | prescribed medicine     |
| Is physically im  | paired but mentally a   | lert and therefore:  |                     |                        |                         |
| stra  | tive code "topical med  | ving oral or topical as u<br>dications" means a med<br>orasion, and eye, nose, | ication other than  | n a debriding agent us | ed in treatment of a    |
|   |                         | ace dose of medication<br>e to do so without spilli                            |                     | d place container to h | nis or her mouth if re- |
|   |                         | inistrating medication<br>mands. PLEASE EXPLAI                                 |                     | more assistance tha    | n outlined above, e.g.  |
|   |                         |  |                     |                        |                         |
| Medical Facility:   |                         |  |                     |                        |                         |
| ddress  |                         |  |                     |                        |                         |
| ity   |                         | Stat   | e Zip Co            | de                     |                         |
|   |                         |  |                     |                        |                         |
| hysician's Name   |                         | Physician's Signa  | iture:              |                        | Date                    |