

Initial Health Assessment
Adult Care Facilities/OAC Rule 5122-33-18
Adult Foster Homes/OAC Rule 5122-35-09

Resident's Name: _____ Age: _____ Sex: _____

Facility Name: _____ Date: _____

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 need to only sign at the end of the form.

Health History: _____

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

Lungs: _____ Heart: _____

Medical Diagnosis: _____

Psychological Diagnosis: _____

Medications (Route and Frequency) List all current Medications:

Food Allergies:

Allergies:

Dietary Requirements: _____

Personal Care Services - Check all assistance required

- | | | | |
|----------------------------------|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Grooming | <input type="checkbox"/> Ambulating |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Toileting | <input type="checkbox"/> Feeding | <input type="checkbox"/> Oral hygiene |

Mantoux Test Initial:

1st Step given: _____
 Date read: _____
 Negative? No Yes

2nd Step given: _____
 Date read: _____
 Negative? No Yes

Capability for Medication Administration

To the Physician: Section 3722.011 of the Ohio Revised Code and Rule 5122-33-18 of the Administrative Code requires that residents who live in adult care facilities be evaluated for their ability to self-administer medications 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 medication. As used in paragraph (C)(3) of rule 5122-33-17 of the administrative code, "topical medication" means a medication other than a debriding agent used in the treatment of a skin condition or minor abrasion, and eye, nose, or ear drops excluding irrigations

____ Needs staff member to place a dose of medication in a container and place container to his or her mouth if resident is physically unable to do so without spilling it.

____ *Resident not capable of self-administering medications because needs more assistance than outlined above, eg. Unable to follow simple verbal commands. **Please Explain:**

Physician's Signature: _____ Date: _____

Physician's Name: _____
 (Please print or type)

Address: _____

City, State, Zip: _____ Phone: _____