

BEREA LAKE TOWERS  
RESIDENT HEALTH ASSESSMENT

INITIAL  
 ANNUAL  
 PERIODIC

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

MEDICAL DIAGNOSES (include developmental diagnoses if applicable): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PSYCHOLOGICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HEALTH HISTORY: \_\_\_\_\_  
\_\_\_\_\_

History of falls?  no  yes, explain: \_\_\_\_\_

History of wandering?  no  yes, explain: \_\_\_\_\_

PHYSICAL EXAM:

WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_ T. \_\_\_\_\_ P. \_\_\_\_\_ R. \_\_\_\_\_

EARS/HEARING

Good  Partially deaf  Completely deaf  
 Limited (must speak loudly)  Aid:  R  L

TEETH \_\_\_\_\_

SKIN \_\_\_\_\_

HEART \_\_\_\_\_

ABDOMEN \_\_\_\_\_

EXTREMITIES \_\_\_\_\_

EYES/VISION

Good  Adequate  Limited Vision  Blind  
 Uses Aid  Unable to read

Glaucoma:  yes  no

Cataract surgery: Dates: R \_\_\_\_\_ L \_\_\_\_\_

NOSE/THROAT \_\_\_\_\_

SCARS \_\_\_\_\_

LUNGS \_\_\_\_\_

HERNIA \_\_\_\_\_

PHYSICAL IMPAIRMENTS \_\_\_\_\_  
\_\_\_\_\_

COGNITIVE FUNCTION:  Normal  Impaired

If impaired:  mild  moderate  severe

PRESCRIPTION MEDICATIONS: List all medications, including route and dosage

\*NOTE: PRN medications **must** include indications/instructions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

MEDICATION ADMINISTRATION (please indicate):

Self Administered

Assistance with  
Self Administration

Requires Administration by  
Licensed Professional



IF ASSISTANCE IS REQUIRED WITH SELF-ADMINISTRATION OF MEDICATIONS, THEN (Check all applicable)

REMINDER

VERIFY DIRECTIONS

OPEN CONTAINER

OBTAIN MEDICATION FROM LOCKED AREA

REMOVING ORAL/TOPICAL MEDICATIONS & ASSIST IN  
APPLYING/CONSUMPTION

REMINDER TO ORDER MEDICATION

IMMUNIZATION HISTORY: Please indicate if the individual has received the following vaccinations.

Pneumovax: Yes \_\_\_\_\_

No \_\_\_\_\_

Date of vaccination: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Influenza (Flu): Yes \_\_\_\_\_

No \_\_\_\_\_

Date of vaccination: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Tetanus: Yes \_\_\_\_\_

No \_\_\_\_\_

Date of vaccination: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(Complete Reverse Side)

**FUNCTIONAL ASSESSMENT:**

ACTIVITIES OF DAILY LIVING	INDEP	NEEDS SUPERV	NEEDS ASSIST
AMBULATING			
EATING			
TOILETING			
NAIL CARE			
BATHING			
GROOMING			
TRANSFERRING			
DRESSING			
ORAL HYGIENE			
HAIR CARE			

INSTRUMENTAL ACTIVITIES OF DAILY LIVING	INDEP	NEEDS SUPERV	NEEDS ASSIST
USING TELEPHONE			
PREPARING OWN MEALS			
ACQUIRING/ USING PUBLIC/ PRIVATE TRANSPORTATION			
HOUSEWORK			
SHOPPING			
LAUNDERING			
HEAVY CHORES			
MANAGING FINANCIAL / LEGAL AFFAIRS			
YARD WORK/ MAINTENANCE			

**TYPE OF CARE OR SERVICE INDIVIDUAL REQUIRES BASED ON THE FUNCTIONAL ASSESSMENT**

- Independent     Minimal Assistance     Moderate Assistance     Maximum Assistance

**DOES THE INDIVIDUAL HAVE APPARENT SIGNS AND SYMPTOMS OF INFECTIOUS DISEASE WHICH IS LIKELY TO BE TRANSMITTED TO OTHER RESIDENTS OR STAFF?**       YES     NO

**DOES THIS INDIVIDUAL REQUIRE 24 HOUR NURSING SUPERVISION?**       YES     NO

Explain: \_\_\_\_\_

**DOES THE INDIVIDUAL NEED SKILLED NURSING SERVICES?**

(Skilled nursing services other than administration of medication, supervision of special diets and application of dressings, may only be provided on a part-time intermittent basis (< 8 hours/day, < 40 hours / week) for no more than 120 days in any 12 month period):

NO     YES    IF YES, TYPE, AMOUNT, FREQUENCY, DURATION: \_\_\_\_\_

**DIET REQUIREMENTS:**

- REGULAR
- NO CONCENTRATED SWEETS
- NO ADDED SALT
- RENAL
- MECHANICAL SOFT

Food Allergies: \_\_\_\_\_

**TUBERCULOSIS SCREENING: MANTOUX TESTING ORDER**

**Physician:** By checking either option and signing the health assessment, you will be giving the **Retirement Community** an order to complete Mantoux TB skin testing for this resident.

\_\_\_\_\_ 2 STEP: 5 T.U. PPD intradermally x 1, if non-significant, repeat dose on 7th day.

\_\_\_\_\_ 1 STEP: 5 T.U. PPD intradermally x 1, \* record of a 2 step or single step Mantoux TB skin test **within one year**, is required if checking this option.

\_\_\_\_\_ NO - Known Reactor, NEED DOCUMENTATION OF A CHEST X-RAY WITHIN PREVIOUS THIRTY DAYS,  
DATE OF CHEST X-RAY \_\_\_/\_\_\_/\_\_\_

**I AM AUTHORIZING THE CONTINUED REFILL OF ALL THE CURRENTLY PRESCRIBED MEDICATIONS UNTIL THIS RESIDENT'S NEXT SCHEDULED APPOINTMENT.**

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

<b>EXAMINER NAME:</b>	
<b>ADDRESS OF EXAMINER:</b>	
<b>PHONE:</b>	

PLEASE RETURN COMPLETED FORM TO:

**Berea Lake Towers**  
**3 Berea Commons**  
**Berea, Ohio 44017**  
**440-243-9050    FAX: 440/243-9178**  
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