Orchard Heights, Inc.

An Affiliate of the Hamister Group, Inc.
10 Lafayette Square, Suite 1900
Buffalo, NY 14203

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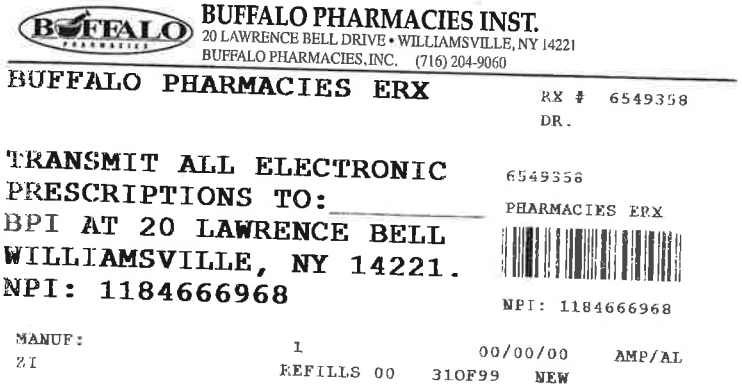
Guidelines for Completion of DOH 3122
Medical Evaluation 25.103(1)

1. **Please place an answer in every category. (None or Not Applicable is accepted. Blanks are not accepted.)**
2. All information must be completed (Personal). This includes the complete address and place of birth.
3. The examination date must be within 30 days of the resident's admission.
4. All medications (including non-prescription drugs) must indicate route, time and dosage.
5. **Please include prescriptions for all medications listed.**
6. An order must be written for a resident to have bed rails, hospital bed, walker, wheelchair, scooter, O^2, urinals, commodes, etc.
7. Alcoholic Beverage orders: Must be specific to when allowed and maximum beverages included or allowed for consumption.
8. **Please print or type the Physician's name under the Signature. The date of the examination must be written. If completed by a Nurse Practitioner, the physician must co-sign his/her signature. Stamped signatures cannot be accepted.**
9. **If attaching a medication list, must be signed and dated by the Physician.**



BUFFALO PHARMACIES INST.
20 LAWRENCE BELL DRIVE • WILLIAMSVILLE, NY 14221
BUFFALO PHARMACIES, INC. (716) 204-9060

BUFFALO PHARMACIES ERX

RX # 6549358
DR.

TRANSMIT ALL ELECTRONIC
PRESCRIPTIONS TO:
BPI AT 20 LAWRENCE BELL
WILLIAMSVILLE, NY 14221.
NPI: 1184666968

6549358
PHARMACIES ERX

NPI: 1184666968

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New York State Department of Health
Division of Home and Community Based Care

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Facility Name:_____ **Date of Exam:**_____

Patient's/Resident's Name:_____ Date of Birth:_____ Sex:_____

Present Home Address:_____
Street City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in condition ☐ Other: _____

MEDICAL REVIEW FINDINGS

Vital Signs: BP:_____ Pulse:_____ Resp:_____ T:_____ Height:_____ ft _____in. Weight:_____

Primary Diagnosis(s): _____

_____

Secondary Diagnosis(s): _____

_____

Allergies: ☐ **None** or list **Known Allergies**: _____

Diet: ☐ Regular ☐ No Added Salt ☐ Limited Concentrated Sweets ☐ Other: _____

Immunizations: ☐ Influenza (Date_____) ☐ Pneumococcal Vaccine (Date_____)

TB SCREENING *(performed **within 30 days prior to initial admission** unless medically contraindicted)*

☐ **Test is contraindicated** **Test**: ☐ TST1 ☐ TST2 ☐ TB Blood Test (Type) _____ Date_____ Result _____

TST1: Date placed _____ Date Read_____ mm_____ TST2: Date placed _____ Date Read_____ mm_____

Based on my findings and on my knowledge of this patient, I find that the patient _____ **IS** _____ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management: _____

LABORATORY SERVICES: ☐ None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency

New York State Department of Health
Division of Home and Community Based Care

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No ☐ Yes ☐
(describe):_____

Dependent on Medical Equipment: No ☐ Yes ☐ (describe):
_____

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1 Ambulate: Independent ☐ Intermittent ☐ Continual ☐
2. Transfer: Independent ☐ Intermittent ☐ Continual ☐
3. Feeding: Independent ☐ Intermittent ☐ Continual ☐
4. Manage Medical Equipment: Manages Independently ☐ Cannot Manage Independently ☐

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendation for follow-up: ☐ None or if yes, describe_____

_____
—

Therapies: ☐ None ☐ Yes (specify): ☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy

Home Care: ☐ None ☐ Yes (specify):_____ Other (specify):
_____

Is Palliative Care Appropriate/Recommended: ☐ No ☐ If yes, describe services:_____

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? ☐ No ☐ Yes

If yes, do you reommened testing be performed: ☐ No ☐ If yes, referral to:_____

If testing has already been performed, date/place of testing if know:_____

MENTAL HEALTH ASSESSMENT (non dementia)

Does the patient have a history of or a current mental disability? ☐ Yes ☐ No
Has the patient ever been hospitalized for a mental health condition? ☐ Yes ☐ No

If Yes, describe:
_____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)

☐ No ☐ Yes Describe:
_____

New York State Department of Health
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ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ **Date:** _____

Resident will receive assistance with all medications unless physician indicates that resident is capable of self-dministration.

1. Does the patient/resident require assistance with medications (see criteria on page 2)? Yes ☐ No ☐
2. List all prescription and OTC medications, supplements and vitamins. Attach additional sheets if necessary or attach current discharge note, signed by the physician, listing ALL medications.

Medication	Dosage	Type	Frequency	Route	Diagnosis/Indication	Prescriber (name of MD/NP)

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR):

- provide 24-hour residential care for dependent adults
- are not medical facilities
- are not appropriate for persons in need of constant medical care and medical supervision and these persons should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services.
- persons who, by reason of age and/or physical and/or mental limitations are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above, or if applicable, an EALR or SNALR.

PHYSICIAN CERTIFICATION

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

☐ **Yes** ☐ **NO** **Is** mentally **suited** for care in an Adult Home/Enriched Housing Program/Assisted Living Residence/Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **NO** **Is** medically **suited** for care in an Adult Home or Enriched Housing Program/Assisted Living Residence/Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **NO** **Is not** in need of continual acute or long term medical or nursing care, including 24-hour skilled nursing care or supervision, which would require placement in a hospital or nursing home.

Name/Title of individual completing form: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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Resident Name: _____ Date: _____

PRN Medications

___ Tylenol (325mg-2 tabs-po q 4 h prn pain/ elevated temp ___ K-Peck 30cc po q 4 h prn diarrhea

___ Robitussin 15cc po q 4 h prn cough ___ Maalox 30cc po q 4 h prn indigestion

___ MOM 30cc po qd prn constipation

Does the patient have the ability to identify the need for the prescribed medications? ___ Yes ___ No

Additional Medications

___**None**

Resident can self manage the following devices:

___ Oxygen (Please describe order)_____

___ Walker ___ W/C (Can Self Propel)

___ Shower Chair ___ Elevated Toilet Seat

___ Cane

___ May receive flu vaccine annually

___ May be served alcoholic beverages at activities with a Two (2) 4-ounce Drink Maximum

___ May Participate in Activities and Exercise Program

PMD Signature:_____ Date:_____