# 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(Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))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<br>☐ IN BED ALL OR MOST OF THE TIME<br>☐ IN BED PART OF THE TIME | COMMENT: |

**TUBERCULOSIS INFORMATION**

| | | |
|---|---|---|
| ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?<br>☐ YES ☐ NO | DATE OF TB TEST | ☐ POSITIVE<br>☐ NEGATIVE |
| ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?<br>☐ 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 |
|---|---|
| | |