



# Physician's Report

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## State of Georgia – Personal Care Home Physician's Report (Separate Form)

All residents living in Assisted Living are required to provide the home with a licensed physician's report of a physical examination dated within thirty (30) days prior to the date of admission.

A physician's report must include:

1. Signature, address, and telephone number of examining physician.
2. Description of physical and mental health status including diagnosis and any functional limitation.
3. Recommendations for care including medication, diet and medical, nursing, health or supportive services, which may be needed on a periodic basis.
4. A statement that, on the day the examination is given:
  - (a) Continuous 24-hour nursing care is not needed.
  - (b) The person's needs can be met in a facility that is not a medical or nursing facility.
  - (c) The person has received screening for tuberculosis and has no apparent signs or symptoms of infectious disease, which is likely to be transmitted to other residents or staff.
  - (d) The person may need assistance with some activities of daily living.

Healthcare Facility Regulation Division  
**PHYSICIAN'S MEDICAL EVALUATION FOR ASSISTED LIVING**

|  |  |  |   |  |        |   |  |   |   |   |  |  |   |
|--|--|--|---|--|--------|---|--|---|---|---|--|--|---|
| NAME OF PATIENT  |  |  | DOB   |  | HEIGHT |   |  |   |   |   |  |  |   |
| PRESENT ADDRESS  |  |  |   |  | WEIGHT |   |  |   |   |   |  |  |   |
| CITY   | STATE  | ZIP  | TELEPHONE   |  |        |   |  |   |   |   |  |  |   |
| <b>REASON FOR EVALUATION:</b><br><input type="checkbox"/> Pre-Admission <input type="checkbox"/> Annual <input type="checkbox"/> Possible change in patient's condition <input type="checkbox"/> Other<br>(Describe) _____   |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 1. Current Diagnosis(es)   |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 2. Physical Limitations  |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 3. Mental Health Limitations   |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 4. Treatment/Therapies (Describe medical services or nursing care or treatment needed.)  |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 5. Supportive Services Needed  |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 6. Allergies   |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 7. DIET INSTRUCTION: <input type="checkbox"/> Regular <input type="checkbox"/> No added table salt <input type="checkbox"/> No concentrated sweets<br><input type="checkbox"/> Other _____   |  |  |   |  |        |   |  |   |   |   |  |  |   |
| 8. STATUS OF THE FOLLOWING: <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"> <b>AMBULATING</b><br/> <input type="checkbox"/> Independent<br/> <input type="checkbox"/> Needs supervision<br/> <input type="checkbox"/> Needs assistance<br/> <input type="checkbox"/> Needs total help<br/> <input type="checkbox"/> Bedridden         </td> <td style="width: 25%; vertical-align: top;"> <b>BATHING</b><br/> <input type="checkbox"/> Independent<br/> <input type="checkbox"/> Needs supervision<br/> <input type="checkbox"/> Needs assistance<br/> <input type="checkbox"/> Needs total help         </td> <td style="width: 25%; vertical-align: top;"> <b>DRESSING</b><br/> <input type="checkbox"/> Independent<br/> <input type="checkbox"/> Needs supervision<br/> <input type="checkbox"/> Needs assistance<br/> <input type="checkbox"/> Needs total help         </td> <td style="width: 25%; vertical-align: top;"> <b>EATING</b><br/> <input type="checkbox"/> Independent<br/> <input type="checkbox"/> Needs supervision<br/> <input type="checkbox"/> Needs assistance<br/> <input type="checkbox"/> Tube feeding         </td> </tr> <tr> <td style="vertical-align: top;"> <b>GROOMING</b><br/> <input type="checkbox"/> Independent<br/> <input type="checkbox"/> Needs supervision<br/> <input type="checkbox"/> Needs assistance<br/> <input type="checkbox"/> Needs total help         </td> <td style="vertical-align: top;"> <b>SKIN INTEGRITY</b><br/> <input type="checkbox"/> No pressure sores<br/> <input type="checkbox"/> Stage one<br/> <input type="checkbox"/> Stage two<br/> <input type="checkbox"/> Stage three<br/> <input type="checkbox"/> Stage four<br/>           Location _____         </td> <td style="vertical-align: top;"> <b>TOILETING</b><br/> <input type="checkbox"/> Independent<br/> <input type="checkbox"/> Needs supervision<br/> <input type="checkbox"/> Hygiene assistance<br/> <input type="checkbox"/> Adult briefs<br/> <input type="checkbox"/> Catheter care assistance<br/> <input type="checkbox"/> Ostomy         </td> <td style="vertical-align: top;"> <b>TRANSFERRING</b><br/> <input type="checkbox"/> Independent<br/> <input type="checkbox"/> Needs supervision<br/> <input type="checkbox"/> Needs assistance<br/> <input type="checkbox"/> Needs total help         </td> </tr> </table> |  |  |   |  |        | <b>AMBULATING</b><br><input type="checkbox"/> Independent<br><input type="checkbox"/> Needs supervision<br><input type="checkbox"/> Needs assistance<br><input type="checkbox"/> Needs total help<br><input type="checkbox"/> Bedridden | <b>BATHING</b><br><input type="checkbox"/> Independent<br><input type="checkbox"/> Needs supervision<br><input type="checkbox"/> Needs assistance<br><input type="checkbox"/> Needs total help | <b>DRESSING</b><br><input type="checkbox"/> Independent<br><input type="checkbox"/> Needs supervision<br><input type="checkbox"/> Needs assistance<br><input type="checkbox"/> Needs total help | <b>EATING</b><br><input type="checkbox"/> Independent<br><input type="checkbox"/> Needs supervision<br><input type="checkbox"/> Needs assistance<br><input type="checkbox"/> Tube feeding | <b>GROOMING</b><br><input type="checkbox"/> Independent<br><input type="checkbox"/> Needs supervision<br><input type="checkbox"/> Needs assistance<br><input type="checkbox"/> Needs total help | <b>SKIN INTEGRITY</b><br><input type="checkbox"/> No pressure sores<br><input type="checkbox"/> Stage one<br><input type="checkbox"/> Stage two<br><input type="checkbox"/> Stage three<br><input type="checkbox"/> Stage four<br>Location _____ | <b>TOILETING</b><br><input type="checkbox"/> Independent<br><input type="checkbox"/> Needs supervision<br><input type="checkbox"/> Hygiene assistance<br><input type="checkbox"/> Adult briefs<br><input type="checkbox"/> Catheter care assistance<br><input type="checkbox"/> Ostomy | <b>TRANSFERRING</b><br><input type="checkbox"/> Independent<br><input type="checkbox"/> Needs supervision<br><input type="checkbox"/> Needs assistance<br><input type="checkbox"/> Needs total help |
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| <b>RESTRAINTS:</b><br><input type="checkbox"/> Requires no restraints <input type="checkbox"/> Requires chemical restraints Type _____ <input type="checkbox"/> Requires physical restraints Type _____  |  |  |   |  |        |   |  |   |   |   |  |  |   |
| (Check all the following that applies as less than avg.)<br><b>IMPAIRMENTS:</b> Sight _____ Hearing _____ Speech _____ Paralysis _____<br>Cane _____ Walker _____ Wheelchair _____<br><b>ASSISTIVE DEVICES:</b> Cooperative _____ Withdrawn _____ Depressed _____ Wanders _____ Disruptive _____<br><b>BEHAVIOR STATUS:</b> Alert _____ Forgetful _____ Confused _____ Delusions _____<br><b>MENTAL STATUS:</b>  |  |  |   |  |        |   |  |   |   |   |  |  |   |

9. CIRCLE THE APPROPRIATE ANSWER IN EACH STATEMENT BELOW.

a. The individual HAS HAS NOT received screening for TB and the individual HAS DOES NOT HAVE signs and/or symptoms of infectious diseases which are likely to be transmitted to other residents or staff.

TB SCREENING INFORMATION: Date: \_\_\_\_\_ Results: \_\_\_\_\_

b. The individual's behavior DOES DOES NOT pose a danger to self or others. If DOES, please explain. If medications are necessary to control behavior, please explain. \_\_\_\_\_

c. The individual DOES DOES NOT require assistance from staff during the night. If assistance is required, please explain. \_\_\_\_\_

d. The individual DOES DOES NOT require 24 hour nursing supervision.

e. The individual DOES DOES NOT require placement in a specialized memory care unit (unit with controlled access/egress designed to serve residents who are at risk of engaging in unsafe wandering activities or other unsafe behaviors).

10. MEDICATIONS: List all medications including over the counter medication, herbal remedies, topical medications, vitamins, etc. Any PRN medications must include instructions, i.e. parameters for us.

| MEDICATION | DOSAGE | DIRECTIONS FOR USE | ROUTE | NEEDS HELP WITH ADMINISTRATION |    |
|------------|--------|--------------------|-------|--------------------------------|----|
|            |        |                    |       | YES                            | NO |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |
|            |        |                    |       |                                |    |

MEDICAL CERTIFICATION SIGNATURE REQUIRED:

Assisted living facilities/personal care homes ARE NOT permitted under the law to provide medical, skilled nursing or Psychiatric care. In your professional opinion, can this patient's needs be safely met in an assisted living facility/personal care home? YES: \_\_\_\_\_ NO: \_\_\_\_\_

COMMENTS:

|                                     |       |                   |
|-------------------------------------|-------|-------------------|
| SIGNATURE OF PHYSICIAN, PA OR NP:   |       | DATE:             |
| PRINTED NAME OF PHYSICIAN, PA OR NP |       | GEORGIA LICENSE # |
| ADDRESS OF PHYSICIAN, PA OR NP      |       | PHONE:            |
| CITY                                | STATE | ZIP CODE          |

PLEASE RETURN COMPLETED FORM TO:

|               |   |
|---------------|---|
| FACILITY NAME | GAINES PARK ASSISTED LIVING<br>1740 OLD 41 HWY<br>KENNESAW, GEORGIA 30152 |
|               | PHONE: (770) 424-1414<br>FAX: (770) 420-1205                              |