



**MEDICAL EVALUATION (page 2)**

Name: \_\_\_\_\_

Is the individual:

Free of communicable disease? \_\_\_ Yes \_\_\_ No. If no, describe: \_\_\_\_\_

\_\_\_\_\_

Able to transfer without assistance? \_\_\_ Yes \_\_\_ No. If no, describe: \_\_\_\_\_

\_\_\_\_\_

Ambulatory without assistance? \_\_\_ Yes \_\_\_ No. If no, describe: \_\_\_\_\_

\_\_\_\_\_

Describe Activity Restrictions/Assistance Needed with ADLs (e.g., eating, transferring, toileting):

Describe Current Treatment Plan (e.g., nursing, therapies, etc.):

Is the individual's condition stable? \_\_\_ Yes \_\_\_ No. If no, describe: \_\_\_\_\_

\_\_\_\_\_

Does the individual have a history, current condition or recent hospitalization for mental disability?

\_\_\_ Yes \_\_\_ No. If yes, describe: \_\_\_\_\_

Is a Mental Health Evaluation recommended? \_\_\_ Yes \_\_\_ No

Date of Today's Examination \_\_\_\_\_ Recommended frequency of Medical Exams \_\_\_\_\_

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared for in an Adult Home, Enriched Housing Program or an ALP.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Nurse Practitioner, Physician or Specialist's Assistant**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Physician (required)**