HEALTH CARE APPRAISAL

Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems

Licensee Name	Resident Name		Case Number
AFC Facility Name	Facility License Number	Worker Name / Load Number	Worker Phone Number

Release of General Medical Information: By signing this form, I understand that I am authorizing the release of medical information concerning me to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident / Legal Guardian	Title	Date

Release of HIV/AIDS Information: By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems, for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident / Legal Guardian	Title	Date

1. Height	2. Weight	3. Ideal Weight Range	4. Blood Pressure	5. Age	6. Sex
					☐ MALE ☐ FEMALE

7. Diagnoses

8. Current Medications and Instructions

9. Allergies

10. General Appearance

11. Mental / Physical Status and Limitations

12. Mobility / Ambulatory Status:

☐ Fully Ambulatory ☐ Uses Walker
☐ Uses Cane ☐ Uses Wheelchair

13. Susceptibility to Hyper / Hypothermia and Related Limitations

14. Special Dietary Instructions and Recommended Caloric Intake

15. Physical Exam:

TYPE	NORM	ABN	** DEFERRED
1. Skin			
2. Ears			
3. Nose			
4. Throat			
5. Mouth			
6. Neck			
7. Breasts			
8. Chest			
9. Lungs			
10. Heart			
11. Abdomen			
12. Extremities Upper			
Lower			
13. Feet / Toes			
14. Lymph Nodes			
15. Genitalia			
16. Testes			
17. Spine			
18. Reflexes			
19. Neurological			
20. Rectal			
21. Sexually Transmitted Diseases	☐ YES	☐ NO	
22. Other:			

**Deferred, as used here, means examination considered but postponed

Explanation of Abnormalities/Treatment Ordered

16. Other Health-Related Information or Concerns

M.D./D.O./P.A. or R.N. (Please Print Name)

Signature	City	State	Zip Code

Address	Title	Date of Signature	Date of Exam

AUTHORITY: 1979 PA 218 R 400.14301(10) and R 400.15301(10)
COMPLETION: Required. R 400.14310 and R 400.15310
CONSEQUENCE: Violation of AFC Licensing Rules. R 400.14313(3) and R 400.15313(3)

LARA is an equal opportunity employer/program.