Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Initial Health Assessment

(Sample)

Adult Care Facilities/OAC Rule 5122-33-18
Adult Foster Homes/OAC Rule 5122-35-09

Resident's Name: _____ Age: _____ Sex: _____

Facility Name: _____ Date: _____

These components may be performed by different health professionals, consistent with the type of information required and the professionals' scope of practice, as defined by applicable law. If different health professionals are used, each professional must sign the section they complete. If a physician is completing the entire assessment, he/she need to only sign at the end of the form.

Health History: _____

_____

Physical:
Height: _____ Weight: _____ BP: _____ Temp: _____ P: _____ R: _____

Lungs: _____ Heart: _____

Medical Diagnosis: _____

_____

Psychological Diagnosis: _____

_____

Medications (Route and Frequency) List all current Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

(Initial health assessment continued)

Allergies: _____

_____

_____

Food Allergies: _____

_____

_____

Dietary Requirements: _____

_____

Personal Care Services - Check all assistance required

☐Bathing ☐Dressing ☐Grooming ☐Ambulating
☐Walking ☐Toileting ☐Feeding ☐Oral hygiene

Mantoux Test Initial:

1st Step given: _____ 2nd Step given: _____
Date read: _____ Date read: _____
Negative? ☐No ☐Yes Negative? ☐No ☐Yes

Capability for Medication Administration

To the Physician: Section 3722.011 of the Ohio Revised Code and Rule 5122-33-18 of the Administrative Code requires that residents who live in adult care facilities be evaluated for their ability to self-administer medications with or without limited assistance. Please mark all statements that apply:

_____ No assistance needed.
_____ Needs assistance to open container and is able to request assistance.
_____ Needs reminders when to take medication.
_____ Needs watching to ensure resident follows directions on the container.
_____ Needs staff to take medications from locked storage and hand it to the resident.
_____ Needs staff to read label and directions upon request.
_____ Needs staff member to remind resident and any other individual designated by the resident when prescribed medicine needs to be refilled.
_____ Is physically impaired but mentally alert and therefore:
  _____ Needs assistance in removing oral or topical medication. As used in paragraph (C)(3) of rule 5122-33-17 of the administrative code, "topical medication" means a medication other than a debriding agent used in the treatment of a skin condition or minor abrasion, and eye, nose, or ear drops excluding irrigations
  _____ Needs staff member to place dose of medication in his or her mouth
_____ *Resident not capable of self-administering medications because needs more assistance than outlined above, eg. Unable to follow simple verbal commands. **Please Explain:**

_____

_____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____
(Please print or type)

Address: _____

City, State, Zip: _____ Phone: _____

Annual Health Assessment

(Sample)

Adult Care Facilities/OAC Rule 5122-33-18

Resident's Name: _____ Age: _____ Sex: _____

Facility Name: _____ Date: _____

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Updated Medical Diagnosis: _____

_____

Updated Psychiatric or Psychological Diagnosis (if applicable): _____

_____

Prescribed Medications (Route and Frequency) List all current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Updated Dietary Requirements: _____

_____

Annual Mantoux SkinTest :

Date Given: _____ Weight: _____

Date read: _____

Results _____

Personal Care Services - Check all prompt/assistance required:

☐Bathing ☐Dressing ☐Grooming ☐Ambulating

☐Walking ☐Toileting ☐Feeding ☐Oral hygiene

Capability for Medication Administration

To the Physician: Section 3722.011 of the Ohio Revised Code and Rule 5122-33-18 of the Administrative Code requires that residents who live in adult care facilities be evaluated for their ability to self-administer medications with or without limited assistance. Please mark all statements that apply:

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_____ Needs watching to ensure resident follows directions on the container.
_____ Needs staff to take medications from locked storage and hand it to the resident.
_____ Needs staff to read label and directions upon request.
_____ Needs staff member to remind resident and any other individual designated by the resident when prescribed medicine needs to be refilled.
_____ Is physically impaired but mentally alert and therefore:
  _____ Needs assistance in removing oral or topical medication. As used in paragraph (C)(3) of rule 5122-33-17 of the administrative code, "topical medication" means a medication other than a debriding agent used in the treatment of a skin condition or minor abrasion, and eye, nose, or ear drops excluding irrigations
  _____ Needs staff member to place dose of medication in his or her mouth
_____ *Resident not capable of self-administering medications because needs more assistance than outlined above, eg. Unable to follow simple verbal commands. **Please Explain:**

_____

_____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____
(Please print or type)

Address: _____

City, State, Zip: _____ Phone: _____

Revised 07/10/2013