

Lavender Hills
Assisted Living LLC
License #'s: 455002027 & 455002615

Admission Assessment Form

Please fill out the entire form as this will help us know if the resident is suitable for our facility.

RESIDENTIAL CARE FACILITY FOR THE ELDERLY

PRE-ADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist licensees in identifying specific medical and behavioral issues that may affect the placement of and/or services to be provided to prospective residents of Residential Care Facilities for the Elderly (RCFE). The questions on this form should be reviewed with the applicant's responsible party prior to admission to the facility. If the answer to any of the questions on this list is yes; the licensee should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs. It is essential for licensees to ensure, to the extent possible, that the resident's history, medical assessment, prior facility records, if applicable and existing conditions are known and care needs understood prior to admission.

This guide is not intended to be a substitute for reading and understanding the regulations. The regulation section is referenced after each question.

The information on this form supplements the Preplacement Appraisal Information form (LIC 603), but does not replace it. While the information gathered from this form should assist licensees in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: _____

Applicant's Name: _____ Date of Birth: _____

Current Residence:

Own home _____ With family _____ Board & Care _____

Skilled nursing facility _____ Hospital _____

Reason(s) for Placement in RCFE: _____
_____
_____
_____

Applicant's Physician: _____
Address: _____
Phone number: _____

Applicant's Responsible Person, (if applicable) _____

A. INCIDENTAL MEDICAL SERVICES ASSESSMENT

YES **NO**

1. Oxygen Administration

☐ ☐ Does the applicant use oxygen? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant use liquid oxygen? If yes, explain. _____

_____

_____

_____

2. Intermittent Positive Pressure Breathing (IPPB) Machine

☐ ☐ Does the applicant use an IPPB? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

3. Colostomy/Ileostomy

☐ ☐ Does the applicant have a colostomy or ileostomy? If yes, explain. _____

_____

_____

_____

YES **NO**

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

4. Enema/Suppository/Fecal Impaction Removal

☐ ☐ Does the applicant need enemas, suppositories or fecal impaction removal? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

5. Catheter Care

☐ ☐ Does the applicant have a catheter? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

6. Bowel and Bladder Incontinence

☐ ☐ Is the applicant incontinent of bowel or bladder? If yes, explain. _____

_____

_____

_____

7. Contractures

☐ ☐ Does the applicant have contractures? If yes, explain. _____

_____

_____

_____

YES **NO**

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

☐ ☐ Do the contractures severely affect the applicant's ability to function? If yes, not allowed in an RCFE._____

_____

_____

_____

8. Diabetes

☐ ☐ Does the applicant have diabetes? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant require assistance with performing or reading glucose tests, drawing up injectable medications or administering injections? If yes, explain. _____

_____

_____

_____

9. Injections

☐ ☐ Does the applicant need any injections? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance with drawing up and administering the injections? If yes, explain._____

_____

_____

_____

YES **NO**

10. Healing Wounds

☐ ☐ Does the applicant have any healing wounds? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant have stage 1 or 2 dermal ulcers (bedsores)? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant have stage 3 or 4 dermal ulcers? If yes, not allowed in an RCFE unless an exception is approved.

11. Bedridden

☐ ☐ Is the applicant bedridden – unable to reposition or transfer in bed? If yes, please explain. _____

_____

_____

_____

☐ ☐ Is the applicant unable to transfer in and out of bed without assistance? If yes, explain. _____

_____

_____

_____

☐ ☐ Is the applicant's bedridden status temporary (less than 14 days)? If yes, explain. _____

_____

_____

_____

☐ ☐ Is the condition permanent or expected to last more than fourteen days? If yes, explain. _____

_____

_____

_____

YES **NO**

12. Gastrostomy

☐ ☐ Does the applicant have a gastrostomy? If yes, not allowed in an RCFE unless an exception is approved.

13. Naso Gastric (NG) Tubes

☐ ☐ Does the applicant have NG tubes? If yes, not allowed in an RCFE.

14. Staph Infection

☐ ☐ Does the applicant have a Staph or other serious infection? If yes, not allowed in an RCFE unless an exception is approved.

15. Total Care

☐ ☐ Does the applicant need total care (assistance with ALL activities of daily living-- eating, bathing, dressing, grooming, toileting and transferring)? If yes, not allowed in an RCFE unless an exception or waiver is approved.

16. Tracheostomies

☐ ☐ Does the applicant have a tracheostomy? If yes, not allowed in an RCFE.

17. Hospice

☐ ☐ Is the applicant currently receiving hospice care? If yes, please see Self-Assessment Guide on Hospice Care.

B. PERSONS WITH DEMENTIA

YES **NO**

☐ ☐ Does the applicant have Dementia?

☐ ☐ Is the applicant mentally able to respond to an emergency signal or instruction? If yes, explain. _____

_____

_____

_____

YES **NO**

☐ ☐ Is the applicant mentally unable to respond to an emergency signal or instruction? If yes, explain. _____

_____

_____

_____

C. BEHAVIORAL ASSESSMENT

Does the applicant have a history of any of the following behaviors?

YES **NO**

☐ ☐ 1. Physical assaultiveness

☐ ☐ 2. Verbal assaultiveness

☐ ☐ 3. Wandering

☐ ☐ 4. Sexual assaultiveness, molestation or inappropriate sexual activity

☐ ☐ 5. Disruptiveness (screaming, throwing things, argumentative)

☐ ☐ 6. Property destruction

☐ ☐ 7. Careless disposal of smoking materials

☐ ☐ 8. Stealing

If the answer to any of the above is yes, describe the behavior: _____

_____

_____

_____

Frequency and duration of the behavior(s): _____

_____

_____

_____

Approximate date of last occurrence: _____

_____

_____

_____

What seems to trigger the behavior: _____

_____

_____

_____

Strategies to deal with the behavior: _____

_____

_____

_____

Does the applicant have a history of any of the following behaviors?

YES	NO	
☐	☐	1. Refusal to take medication
☐	☐	2. Refusal to get medical attention
☐	☐	3. Refusal to bathe or wear clean clothing
☐	☐	4. Non-compliance with house rules
☐	☐	5. Self-abuse
☐	☐	6. Suicide attempts or suicidal thoughts
☐	☐	7. Depression
☐	☐	8. Alcohol or drug abuse

If the answer to any of the above is yes, describe the behavior: _____

_____

_____

_____

Frequency and duration of the behavior(s): _____

_____

_____

_____

Approximate date of last occurrence: _____

_____

_____

_____

What seems to trigger the behavior: _____

_____

_____

_____

Strategies to deal with the behavior: _____

_____

_____

_____

D. MISCELLANEOUS

YES **NO**

☐ ☐ 1. Does the applicant currently use any prescription or over-the-counter medications? If yes, please list.

Medication Name	Strength	Dose	Times

☐ ☐ 2. Does the applicant currently use any prescription or over-the-counter medications on a PRN basis? If yes, please list. _____

_____

_____

_____

☐ ☐ 3. Does the applicant have any emergency medication that must be kept with him/her or at bedside? If yes, please list. _____

_____

_____

_____

☐ ☐ 4. Will the applicant be willing to have all of his/her medications, including over-the-counter medications, centrally stored?

YES **NO**

5. Does the applicant use any of the following devices?

☐ ☐ Glasses
☐ ☐ Dentures
☐ ☐ Hearing Aid
☐ ☐ Other _____

6. Does the applicant need assistance with any of the following?

☐ ☐ Eating. If yes, explain. _____
_____
_____
_____

☐ ☐ Bathing. If yes, explain._____
_____
_____
_____

☐ ☐ Dressing. If yes, explain._____
_____
_____
_____

☐ ☐ Grooming. If yes, explain._____
_____
_____
_____

☐ ☐ Toileting. If yes, explain._____
_____
_____
_____

7. Does the applicant use any of the following?

☐ ☐ Cane. If yes, explain.
_____
_____
_____

☐ ☐ Crutch. If yes, explain._____
_____
_____
_____

YES **NO**

☐ ☐ Walker. If yes, explain. _____
_____
_____
_____

☐ ☐ Wheelchair. If yes, explain.
_____
_____
_____

☐ ☐ 8. Does the applicant have any paralysis? If yes, explain (site, degree, assistance needed)
_____
_____
_____

☐ ☐ 9. Does the applicant require a special diet? If yes, explain. _____
_____
_____
_____

☐ ☐ 10. Does the applicant have any skin condition or history of skin breakdown? If yes, explain. _____
_____
_____
_____

☐ ☐ 11. Will the applicant require transportation to any appointments or events other than routine local medical appointments? If so, where and how often? _____
_____
_____
_____

Applicant/Responsible Person: _____
(Signature)

Date: _____

Facility Representative: _____
(Signature)

Date: _____

Attachments:

☐ **YES** ☐ **NO**