INITIAL PLACEMENT

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| **Name:**       | **DOB:**       |
| **Physician Name:**       | **Clinic:**       |
| **Date of Exam (must be within 90 days prior to placement):**       |
| **Medical Diagnoses:**       |
| **Allergies:**  |
| **Diet:**       |
| **Height:**  | **Weight:**  | **Blood Pressure:**  |

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| **Medication(s) with dose and reason:**  |

**Medication Administration:**

Does the person require assistance from the Adult Family Home, or other substitute care provider, for medication administration? Assistance refers to any aspect of medication storage or administration.

[ ]  Yes, I authorize the AFH, or other substitute provider/caregiver, to assist with medication administration for the above-named person.

[ ]  No, the above-named person is capable of taking medications independently without prompts or monitoring.

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| **Communicable Disease:** \*\*Mantoux (TB) test must be given within **90 days prior to placement**. |
| [ ]  I certify the above-named person is free from communicable disease as evidenced by: |
| Mantoux (TB) test date:        | Result:        |
| If Mantoux is positive, Chest X-Ray date:        | Result:        |
| [ ]  The above person has a communicable disease. Please explain:       |
| **Concerns/Comments:**  |

**Physician, Physician’s Assistant, or Nurse Practitioner Signature Date**