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**