# ADULT RESIDENTIAL LICENSING – PERSONAL CARE HOMES
# RESIDENT MEDICAL EVALUATION - 55 Pa.Code § 2600.141

*(To be completed within 60 days prior to admission or within 30 days after admission)*
*Required for ALL residents. For residents who receive SSI a MA-51 medical evaluation form is also required.*

| ☐ NEW ☐ UPDATED | 1. NAME OF APPLICANT | 2. SOCIAL SECURITY NUMBER | 3. BIRTHDATE | 4. AGE | 5. SEX |
|---|---|---|---|---|---|
| | | | | | |

| 6. PHYSICIAN NAME (Printed) | 7. PHYSICIAN SIGNATURE | 8. DATE | 9. PHYSICIAN LICENSE NUMBER |
|---|---|---|---|
| | | | |

| 10. HEIGHT | WEIGHT | BLOOD PRESSURE | TEMPERATURE | PULSE RATE |
|---|---|---|---|---|
| | | | | |

**11. MEDICAL HISTORY:** (Attach a signed and dated separate sheet if additional documentation is necessary)

**12. DIAGNOSES:**

**13. COMMUNICABLE DISEASE:** **Is the individual free of Communicable Disease?** ☐ Yes ☐ No

**14. IMMUNIZATIONS:** **Are immunizations up-to-date?** ☐ Yes ☐ No ☐ Unknown

**Tetanus / Diphtheria / Acellular Pertussis (Td/Tdap) (every 10 years) Date:** ____________________

**Influenza (every year) Date:** ____________________ **Other – List Immunization & Date:** ____________________

**15. ALLERGIES - List known allergies:** (Attach a signed and dated separate sheet if additional documentation is necessary) ☐NONE ☐UNKNOWN

**16. EMERGENCY EVACUATION - Mobility Needs:**
**In the event of an emergency, how much assistance does the applicant require to vacate the building?** (Check All Applicable)

- ☐ Unable to move from one location to another without physical assistance from others
- ☐ Unable to move from one location to another without oral prompting from others
- ☐ Difficulty understanding and following oral directions in the event of an emergency
- ☐ Independently mobile with ambulation device. Specify device used: ____________________
- ☐ Walks without assistance

**17. MEDICATION ADMINISTRATION – Self-Administer Medications:**
**Is the applicant capable of administering his/her own medications?** (Check All Applicable)

- ☐ Can self-administer medications with no assistance from others
- ☐ Can self-administer medications with assistance to store medications in a secure place
- ☐ Can self-administer medications with assistance in remembering schedule
- ☐ Can self-administer medications with assistance in offering medications at prescribed times
- ☐ Can self-administer medications with assistance in opening container or locked storage area

**OR (Check)**

- ☐ Cannot self-administer medications

**18. RECOMMENDATION FOR APPROPRIATE LEVEL OF CARE:**

- ☐ Nursing Care
- ☐ Personal Care Home
- ☐ Independent Living without supports
- ☐ Independent Living with in-home supports
- ☐ Specialized Care (Specify Type: ____________________ ____________________)

**19. PHYSICIAN ORDERS** (Record as "NONE" if there are no special needs related to the following):

Medications ☐NONE ____________________

Treatment/Therapies ☐NONE ____________________

Diet ☐NO SPECIAL DIET ____________________

Activities/Social Services ____________________

Body Positioning ☐N/A ____________________