ADULT CARE HOME
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN

Assessment Date ___/___/___
Reassessment Date ___/___/___
☐ Significant Change___/___/___

RESIDENT INFORMATION

(Please Print or Type)

RESIDENT _____ SEX (M/F) ____ DOB ____/____/____ MEDICAID ID NO. _____

FACILITY _____

ADDRESS _____

_____PHONE _____ PROVIDER NUMBER _____

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN _____/_____/_____

ASSESSMENT

1. MEDICATIONS – Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	**Dose**	**Frequency**	**Route**	**(✓) If Self-Administered**
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

☐ Wandering
☐ Verbally Abusive
☐ Physically Abusive
☐ Resists care
☐ Suicidal
☐ Homicidal
☐ Disruptive Behavior/ Socially Inappropriate

☐ Injurious to:
☐ Self ☐ Others ☐ Property

Is the resident currently receiving medication(s) for mental illness/behavior?
☐ YES ☐ NO

Is there a history of:
☐ Substance Abuse
☐ Developmental Disabilities (DD)
☐ Mental Illness

Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? ☐ YES ☐ NO

Has a referral been made? ☐ YES ☐ NO

If YES:

Date of Referral _____

Name of Contact Person _____

Agency _____

Social/Mental Health History: _____
_____
_____
_____
_____
_____
_____
_____