

WINDSOR COURT ASSISTED LIVING

Assisted Living / Physician Assessment Form

Resident Name _____

Birth Date _____ Telephone _____

Street Address _____

City/State/Zip _____

Other Emergency Contact

Or Representative _____

Telephone _____

Street Address _____

City/State/Zip _____

Purpose of assessment:

- Prior to move-in at Windsor Court
- Annual
- Significant change in condition

Windsor Court

401 Burwash Avenue

Savoy, IL 61874

Phone 217-351-1490 Fax 217-351-7224

The Assisted Living and Shared Housing Act require every resident, prior to admission, annually, and upon identification of significant change in condition, to receive a comprehensive physician's assessment. The assessment must include an evaluation of the person's physical, cognitive, and psychosocial condition.

The Act prohibits persons having certain conditions or limitations and requiring certain types of care from residing in an establishment. A list of these conditions appears in Section IV on the last page of this document.

Section I

I certify that the following have been completed:

- A physical, psychosocial, and cognitive assessment
- Written instructions, as appropriate, contained in Section II
- Communicable disease information, contained in Section III

I further certify that in my professional judgment this person meets the conditions, limitations, and care requirements specified in the Assisted Living and Shared Housing Act as outlined in **Section IV** of this document.

Physician Name _____ ID # _____

(Please print)

Signature _____ Date _____

Section II

Personal Service Needs: Based upon my assessment, the resident's condition warrants assistance with the following personal services: (Note any specific needs and instruction.)

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Eating |
| <input type="checkbox"/> | <input type="checkbox"/> | Dressing |
| <input type="checkbox"/> | <input type="checkbox"/> | Bathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Toileting |
| <input type="checkbox"/> | <input type="checkbox"/> | Personal Hygiene |
| <input type="checkbox"/> | <input type="checkbox"/> | Escort / Mobility / Transferring |
| <input type="checkbox"/> | <input type="checkbox"/> | * Can this person administer his or her own medication? |
| <input type="checkbox"/> | <input type="checkbox"/> | * Does this person have any need for home health services? |
| <input type="checkbox"/> | <input type="checkbox"/> | * Is there a need for periodic nutritional assessment? |
| <input type="checkbox"/> | <input type="checkbox"/> | * Is there a need for periodic assessment of skin integrity? |

***Please explain:**

Section III

Communicable, contagious, or infectious disease: Based upon my assessment this person is free of communicable disease

Yes **No**
 This person received a **TB test** during the past year **Date** _____
Result: _____ *Positive* _____ *Negative*

If positive response, describe follow-up testing or treatment and dates initiated:

 This person received a negative chest X-ray in past year **Date** _____
 This person may receive an annual flu vaccine
Date of last flu vaccine _____

 This person may receive a pneumonia vaccine
Date of last pneumonia vaccine _____

 This person is free from communicable disease

Signature: _____ **Date:** _____

Section IV

Illinois Department of Public Health Assisted Living and Shared Housing Code

Residency Conditions, Care and Limitations

An Assisted Living facility may only accept adults for residency.

The facility may not accept or retain individuals whose needs cannot be met by the facility, who pose a threat to themselves or others, who have a severe mental illness, or are unable to communicate their needs unless there is a resident representative living in the facility. (Mental illness does not include Alzheimer's disease or other forms of dementia.)

The residents may not require any of the following:

- Total assistance with 2 or more ADL's (activities of daily living)
- Intravenous and/or gastrostomy feeding therapy*
- More than minimal assistance in moving to a safe area in an emergency
- Insertion, sterile irrigation, or replacement of urinary catheter*
- Sterile wound care*
- Treatment of stage 3 or 4 decubitus ulcers or exfoliative dermatitis
- Five or more skilled nursing visits per week for a period of three consecutive weeks or more, except when the treatment is for rehabilitative purposes and is certified by a physician.
- Terminally ill residents may remain in an assisted living facility if they are enrolled in a hospice program.
- There is an exception to some of the admission limitations for quadriplegic, paraplegic, and individuals with neuro-muscular diseases such as muscular dystrophy and multiple sclerosis.

**Unless this care is self-administered or administered by a qualified licensed health care professional*