# PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

**For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).**

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

## FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: | TELEPHONE:

ADDRESS: NUMBER STREET CITY

LICENSEE'S NAME: | TELEPHONE: | FACILITY LICENSE NUMBER:

## RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: | TELEPHONE:

ADDRESS: NUMBER STREET CITY | SOCIAL SECURITY NUMBER:

NEXT OF KIN: | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

## PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: | HEIGHT: | SEX: | WEIGHT: | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ **YES** ☐ **NO**

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ **YES** ☐ **NO** If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:
B) ☐ **YES** ☐ **NO** If YES, list below:

ALLERGIES
C) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:
D) ☐ **YES** ☐ **NO** If YES, list below:

Ambulatory status of client/resident: ☐ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

| I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR | COMMENTS: | | | |
|---|---|---|---|---|
| | YES (Check One) | NO (Check One) | ASSISTIVE DEVICE | COMMENTS: |
| 1. Auditory impairment | | | | |
| 2. Visual impairment | | | | |
| 3. Wears dentures | | | | |
| 4. Special diet | | | | |
| 5. Substance abuse problem | | | | |
| 6. Bowel impairment | | | | |
| 7. Bladder impairment | | | | |
| 8. Motor impairment | | | | |
| 9. Requires continuous bed care | | | | |

| II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR | COMMENTS: | | | |
|---|---|---|---|---|
| | NO PROBLEM | OCCASIONAL | FREQUENT | IF PROBLEM EXISTS, PROVIDE COMMENT BELOW: |
| 1. Confused | | | | |
| 2. Able to follow instructions | | | | |
| 3. Depressed | | | | |
| 4. Able to communicate | | | | |

| III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO | COMMENTS: | | |
|---|---|---|---|
| | YES (Check One) | NO (Check One) | COMMENTS: |
| 1. Able to care for all personal needs | | | |
| 2. Can administer and store own medications | | | |
| 3. Needs constant medical supervision | | | |
| 4. Currently taking prescribed medications | | | |
| 5. Bathes self | | | |
| 6. Dresses self | | | |
| 7. Feeds self | | | |
| 8. Cares for his/her own toilet needs | | | |
| 9. Able to leave facility unassisted | | | |
| 10. Able to ambulate without assistance | | | |
| 11. Able to manage own cash resources | | | |

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

| CONDITIONS | OVER-THE-COUNTER MEDICATION(S) |
|---|---|
| 1. Headache | _____ |
| 2. Constipation | _____ |
| 3. Diarrhea | _____ |
| 4. Indigestion | _____ |
| 5. Others *(specify condition)* | |
| _____ | _____ |
| _____ | _____ |

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

| | | |
|---|---|---|
| 1. _____ | 4. _____ | 7. _____ |
| 2, _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

| PHYSICIAN'S NAME AND ADDRESS: | TELEPHONE: | DATE: |
|---|---|---|
| | | |

PHYSICIAN'S SIGNATURE

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION** (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

| SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE | ADDRESS: | DATE: |
|---|---|---|
| | | |