STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CAR LICENSING

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 type 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 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	SSN:
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 UNER 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 __Non-ambulatory

Health and safety code section 13131 provides: "Non-ambulatory persons" means person 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 non-ambulatory 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 non-ambulatory 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	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 EXISTTS, 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	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			
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: (NAME AND ADDRESS OF LICENSING AGENCY):		

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