STATE OF FLORIDA
DEPARTMENT OF ELDER AFFAIRS
RESIDENT HEALTH ASSESSMENT FOR ASSISTED LIVING FACILITIES (ALF)

NAME:	DOB:	
KNOWN ALLERGIES:	HEIGHT:	WEIGHT:

HEALTH ASSESSMENT
Medical history and diagnoses:
Physical orsensory limitations:
Cognitive or behavioral status:
Nursing/treatment/therapy service requirements:
Special precautions:

To what extent does the individual need supervision/assistance with the following?

AMBULATION:
__ Independent
__ Needs Supervision
__ Needs Assistance
__ Needs Total Help

BATHING:
__ Independent
__ Needs Supervision
__ Needs Assistance
__ Needs Total Help

DRESSING:
__ Independent
__ Needs Supervision
__ Needs Assistance
__ Needs Total Help

TOILETING:
__ Independent
__ Needs Supervision
__ Needs Assistance
__ Incontinence
__ Catheter Care
__ Ostomy Assistance

EATING:
__ Independent
__ Needs Supervision
__ Needs Assistance
__ Tube Feeding

GROOMING:
__ Independent
__ Needs Supervision
__ Needs Assistance
__ Needs Total Help

TRANSFERRING:
__ Independent
__ Needs Supervision
__ Needs Assitance
__ Needs Total Help

Special Diet Instructions?

__ Regular
__ Diabetic Diet
__ No Added Salt
__ Low Fat/Low Cholesterol

__ Other, please describe:____

____
___

Please list all current medications prescribed (additional pages may be attached)

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.			
2			
3			
4			
5.			
6.			

Does the individual need help with their medications? Yes ___ No ___. If yes, please describe:

Does the individual have any of the following conditions/requirements ?

STATUS	YES	NO	COMMENTS
A communicable disease which could be transmitted to other residents or staff?			
Bedridden?			
Any stage 2, 3, or 4 pressure sores?			
Pose a danger to self or others?			
Require 24 hour nursing or psychiatric care?			

In your professional opinion can this individual's needs be met in a residential facility that is not a medical, or nursing, or psychiatric facility (i.e., assisted living facility)? Yes ___ No

SIGNATURE____

MD or DO/ARNP

DATE OF EXAMINATION:	- PLEASE RETURN COMPLETED FORM TO -
NAME OF EXAMINER (Printed):	ALF FACILITY: **Central Tampa ALF**
FLORIDA LICENSE #:	CONTACT PERSON: **Sangita /Care Coordinator**
ADDRESS OF EXAMINER:	ADDRESS OF FACILITY: **5010 N 40th St. Tampa, FL 33601**
PHONE #:	PHONE #: **813-663-9696**