PINNACLE
ASSISTED LIVING SERVICES

Health Assessment for Pinnacle Assisted Living Services CBRF/AFH Placement

Name _____ Birth date _____ today's Date_____

Allergies_____

_____

_____

_____

Chronic medical conditions _____

_____

_____

_____

_____

Previous surgeries _____

_____

_____

_____

Additional comments/treatments required _____

_____

_____

_____

_____

A TB skin test is required. A chest x-ray is required for a past positive TB skin test.

TB skin test administer on _____ by _____
Date read _____ By_____ Results _____

This person is free of communicable diseases. _____ Yes _____ No

It is my finding that the above-named person is free of communicable diseases including tuberculosis. This person does not have an illness or condition that would threaten the health, safety, or welfare of residents and/or caregivers.

_____

Physician's Signature **Date**

See "Medication Authorization" form which addresses medication and provider administration.