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PRE-VISIT RESIDENT INFORMATION FORM

For RCFE / Assisted Living / Memory Care Placement

Please attach any available current medication list, recent physician/primary care note or medical history, recent hospital or emergency department discharge summary (if applicable), POLST or Advance Directive, and TB screening/clearance documentation.

This is a pre-visit information form used to gather information for the LIC 602A evaluation. It is not the state LIC 602A form and does not replace the in-person or telehealth clinical evaluation when one is required.

RESIDENT INFORMATION

Resident Name:

Date of Birth:

Person Completing Form:

Relationship to Resident:

Phone Number:

Email:

Primary Care Provider:

Date of Last Primary Care Visit:

Facility Resident Is Applying To:

Approximate Height:

Approximate Weight:

Current Residence / Location (if different):

Anticipated Move-In Date (if known):

PERSON COMPLETING FORM / DPOA OR RESPONSIBLE PARTY

Name:

Relationship:

Phone Number:

Email:

Does this person have authority to assist with healthcare or placement decisions? ☐ Yes ☐ No

If yes, please attach applicable documentation (DPOA, Conservatorship, etc.).

MEDICATIONS

Are there any medication allergies? ☐ Yes ☐ No

If yes, please list:

Please attach a current medication list if available or bring medication bottles.

Does the resident take medications every day? ☐ Yes ☐ No

Does someone help with medications? ☐ Yes ☐ No

Can the resident manage medications completely alone? ☐ Yes ☐ No ☐ Unsure

Insulin or injections

☐ Yes ☐ No

Blood sugar testing

☐ Yes ☐ No

Oxygen

☐ Yes ☐ No

CPAP machine

☐ Yes ☐ No

Blood thinner monitoring

☐ Yes ☐ No

If yes to any of the above, can they perform these tasks independently? ☐ Yes ☐ No ☐ Unsure

Uses PRN / as-needed medications

☐ Yes ☐ No

Uses inhalers, nebulizers, eye drops, or other special medication devices

☐ Yes ☐ No

Has medications that require crushing, splitting, or special administration instructions

☐ Yes ☐ No

Medication comments / concerns:

MEDICAL DIAGNOSES

Please list all known current medical and psychiatric diagnoses:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Other significant medical conditions or recent health concerns:

SPECIAL HEALTH CARE NEEDS / DEVICES**Important: If any of the following apply, please describe the care or assistance required. Please also confirm with the prospective facility that it can accommodate the resident's identified health care needs and equipment.**Urinary catheter ☐ Yes ☐ No Ostomy (colostomy / ileostomy / urostomy) ☐ Yes ☐ NoG-tube / feeding tube ☐ Yes ☐ No Dialysis ☐ Yes ☐ NoOxygen ☐ Yes ☐ No CPAP / BiPAP ☐ Yes ☐ NoCurrent wound care ☐ Yes ☐ No

If yes to any above, please describe the care or assistance required:

HOSPICE SERVICESIs the resident currently receiving hospice services? ☐ Yes ☐ No

If yes, reason/primary diagnosis for hospice services:

MEMORY & DECISION-MAKINGHas a physician ever diagnosed memory loss, dementia, or Alzheimer's disease? ☐ Yes ☐ No ☐ UnsureDoes the resident frequently forget things? ☐ Yes ☐ NoDoes the resident require reminders for daily activities? ☐ Yes ☐ NoCan the resident generally make their own decisions? ☐ Yes ☐ No ☐ SometimesIs there a responsible family member, Power of Attorney, Conservator, or other decision-maker? ☐ Yes ☐ No

If yes, please provide name:

*If this individual is authorizing the evaluation, please attach documentation.*Is the resident able to state where they are and why they are moving? ☐ Yes ☐ No ☐ UnsureHas the resident recently had a significant change in memory, confusion, or judgment? ☐ Yes ☐ No ☐ Unsure**BEHAVIORAL CONCERNS**

Wandered away or become lost?	☐ Yes ☐ No
Become physically aggressive?	☐ Yes ☐ No
Become verbally aggressive?	☐ Yes ☐ No
Experienced hallucinations?	☐ Yes ☐ No
Experienced delusions/paranoia?	☐ Yes ☐ No
Regularly refused care/medications?	☐ Yes ☐ No
Attempted to leave a facility or home unsafely?	☐ Yes ☐ No
Called 911 repeatedly or made unsafe emergency calls?	☐ Yes ☐ No
Had nighttime wandering, severe sleep reversal, or frequent nighttime agitation?	☐ Yes ☐ No
Required 1:1 supervision for safety?	☐ Yes ☐ No

Comments:

SAFETY AWARENESS / BEHAVIORAL SAFETY

Please answer based on the resident's usual behavior and abilities. These questions are intended to help assess the behavioral safety items addressed on the LIC 602A.

Does the resident demonstrate a lack of awareness of hazards or unsafe situations? ☐ Yes ☐ No ☐ Unsure

Does the resident demonstrate a lack of impulse control that could create a safety concern? ☐ Yes ☐ No ☐ Unsure

Does the resident wander in a way that may be unsafe or require supervision? ☐ Yes ☐ No ☐ Unsure

Has the resident attempted to leave or left a home, facility, or other safe setting without appropriate supervision (elopement)? ☐ Yes ☐ No ☐ Unsure

Do any of the behaviors above create a danger to the resident or others or require additional supervision? ☐ Yes ☐ No ☐ Unsure

If yes or unsure to any item above, please describe:

IMPORTANT SAFETY QUESTIONS

In an emergency, can the resident physically and mentally respond to a fire alarm/sensory signal or oral instruction relating to fire or other danger and leave the building unassisted? ☐ Yes ☐ No ☐ Unsure

Can the resident safely leave a building independently and return without becoming confused or lost? ☐ Yes ☐ No ☐ Unsure

Would the resident likely become lost or disoriented if outside alone? ☐ Yes ☐ No ☐ Unsure

Does the resident require assistance to evacuate a building due to mobility limitations? ☐ Yes ☐ No ☐ Unsure

Can the resident understand and follow simple emergency instructions? ☐ Yes ☐ No ☐ Unsure

Can the resident use stairs in an emergency if necessary? ☐ Yes ☐ No ☐ Unsure

Has the resident fallen within the past 30 days? ☐ Yes ☐ No ☐ Unsure

DAILY CARE NEEDS

Activity	No Help	Some Help	Full Help
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Toileting	☐	☐	☐
Walking	☐	☐	☐
Eating	☐	☐	☐
Brushing Teeth	☐	☐	☐

Activity	No Help	Some Help	Full Help
Grooming / personal hygiene	☐	☐	☐
Transferring	☐	☐	☐
Managing hearing aids / glasses / dentures	☐	☐	☐

TOILETING / CONTINENCE

Urinary incontinence? ☐ Yes ☐ No

Bowel incontinence? ☐ Yes ☐ No

Does the resident wear briefs or protective undergarments? ☐ Yes ☐ No

Does the resident require reminders or scheduled toileting? ☐ Yes ☐ No ☐ Unsure

Does the resident require hands-on assistance with toileting or hygiene? ☐ Yes ☐ No ☐ Unsure

WALKING & TRANSFERS

Is the resident able to independently transfer to and from bed? ☐ Yes ☐ No

Walker ☐ Yes ☐ No

Cane ☐ Yes ☐ No

Wheelchair ☐ Yes ☐ No

Can the resident transfer independently in and out of bed, a chair, or a toilet? ☐ Yes ☐ No ☐ Sometimes

Does the resident require special lift equipment? ☐ Yes ☐ No

If yes, describe:

Uses a hospital bed ☐ Yes ☐ No

Uses a gait belt or requires two-person assistance ☐ Yes ☐ No

Can the resident walk at least short distances without another person physically assisting? ☐ Yes ☐ No ☐ Unsure

Recent falls / mobility comments:

BEDRIDDEN STATUSDoes the resident spend most of the day in bed? ☐ Yes ☐ NoCan the resident get out of bed without assistance? ☐ Yes ☐ No ☐ SometimesDoes the resident need repositioning or assistance turning in bed? ☐ Yes ☐ No ☐ Unsure**EATING & DIET**Are there any food allergies? ☐ Yes ☐ No

If yes, list:

Eat a regular diet?	☐ Yes ☐ No
Require chopped food?	☐ Yes ☐ No
Require pureed food?	☐ Yes ☐ No
Require thickened liquids?	☐ Yes ☐ No
Has the resident ever had difficulty swallowing or choking while eating or drinking?	☐ Yes ☐ No ☐ Unsure
Needs assistance or cueing to eat or drink	☐ Yes ☐ No
Uses dentures / partials	☐ Yes ☐ No
Has had recent unplanned weight loss or poor appetite	☐ Yes ☐ No

Comments:**RECENT HEALTH CHANGES (LAST 6 MONTHS)**

Hospital stay?	☐ Yes ☐ No
Emergency Room visit?	☐ Yes ☐ No
Fall?	☐ Yes ☐ No
Infection?	☐ Yes ☐ No
Significant decline?	☐ Yes ☐ No
New or worsening confusion?	☐ Yes ☐ No
New wound / skin breakdown?	☐ Yes ☐ No
New oxygen requirement or breathing problem?	☐ Yes ☐ No
New difficulty walking or transferring?	☐ Yes ☐ No
New swallowing problem or weight loss?	☐ Yes ☐ No

Comments:**CURRENT TREATMENTS / SPECIAL HEALTH SERVICES**

Home health nursing	☐ Yes ☐ No
Physical therapy	☐ Yes ☐ No
Occupational therapy	☐ Yes ☐ No
Speech therapy	☐ Yes ☐ No
Wound care	☐ Yes ☐ No
Podiatry	☐ Yes ☐ No
Respiratory therapy / nebulizer treatments	☐ Yes ☐ No

Agency / provider names, frequency, and comments:**ADVANCE DIRECTIVES**POLST? ☐ Yes ☐ No ☐ UnsureAdvance Directive? ☐ Yes ☐ No ☐ UnsureDNR Order? ☐ Yes ☐ No ☐ Unsure*Please provide copies if available.***TB SCREENING**Has the resident had TB clearance within the past year? ☐ Yes ☐ No ☐ Unsure

Date of most recent TB screening / clearance: _____

If yes, what type? ☐ TB Skin Test (PPD) ☐ QuantiFERON Blood Test ☐ Chest X-Ray

If the resident previously had a positive TB test, was a chest x-ray completed? ☐ Yes ☐ No ☐ Unsure

Please provide copies of any TB documentation available.

DOCUMENTS / RECORDS

If available, please provide: current medication list; recent physician/primary care progress note or medical history; recent hospital or emergency department discharge summary, if applicable; POLST or Advance Directive, if available; and TB screening/clearance documentation.

CONSENT

I certify that the information provided above is accurate to the best of my knowledge. I understand that this information may be used to assist with completion of the LIC 602A evaluation and may be shared with the assisted living or memory care facility involved in the placement process.

This pre-visit information form does not replace the LIC 602A Medical Assessment.

Name:

Date:

Signature:

Relationship to Resident:

Before the evaluation: Please send or bring the completed form and any available records listed above. If information is unknown, mark "Unsure" rather than guessing. Additional assessment may be needed when there are questions about cognition, medication self-management, walking/transfers, evacuation ability, swallowing, wounds, oxygen, injections, or other special health needs.