Christina's Assisted Living
1423 S. Hazel St., Gilbert, AZ 85296
Fax: 480-452-1525

PRE-ADMISSION DETERMINATION

Resident Name: _____ Admission Date:_____

Diagnosis: _____

A manager shall ensure that before or at the time of acceptance of an individual, the individual submits documentation that is dated within **90 calendar days** before the individual is accepted by an assisted living facility and:

Is the individual (resident) requesting or is expected to receive (check all that applies)

☐ Supervisory Care Services - General supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in the self-administration of prescribed medications.

☐ Personal Care Services - Assistance with activities of daily living that can be performed by persons w/o professional skills or professional training and includes coordination or provision of intermittent nursing services and the administration of medications and treatments by a licensed nurse.

☐ Directed Care Services - Programs and services, including personal care services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic decisions

This facility does not accept residents who require the following: Please circle all that applies

Continuous medical services-hospital	Yes	No
Continuous nursing services - Rehab/nursing homes	Yes	No
Restraints (Physical or medical)	Yes	No
Intermittent nursing services (hospice, home health, PT, etc..)	Yes	No
if yes, explain: _____		
Assisted Living Services	Yes	No

.
Physician/PA/Med. Practitioner/RN Signature: _____

Date: _____

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Doctor's Orders Initial Admission (AR-5)

Dear Dr. _____,

Your patient _____ has recently become a resident of

Christina's Assisted Living

In order for us to provide the best care for this resident, and in order to comply with state regulations regarding the administration of medications, treatments and special diets, please provide the following information: (Additional sheets may be attached, if necessary)

1. Please provide instructions for all current medications this resident is receiving:

Medication Name	Dosage	Route of Administration	Time of Administration	Notes

2. Please provide complete instruction for all treatments this resident is currently receiving which may require the assistance or supervision of the care home.

_____

_____

_____

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3. Please list any dietary restrictions; supplements or special diets for this resident along with complete instructions:

4. Additional Instruction or Recommendations:

AUTHORIZATION:

Resident Manager and/or Caregiver are authorized to administer medications, refill medisets and/or treatments to this resident.

Physician Signature Date

Next Appointment Schedule: _____

Please complete the following:

Blood Pressure: _____

Respiration: _____

Temperature: _____

Pulse Rate: _____

Weight: _____

Height: _____

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Additional Form for Medications List (if Applicable) Date: _____

Medications Name	Dosage	Route	Time	Notes/Changes

Physician Name: _____Signature:_____

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PHYSICIAN'S ORDER FOR ADULT CARE HOME LICENSURE
(Medication Organizers)

Resident's Name: _____

Date: _____

Dear Dr. _____,

In order to be in compliance with the Department of Health Services, we need to have the residential care home's policies involving medications reviewed by the resident's physician. In addition, we need a signed order from each physician stating that a certified manager may set up the medication organizers (medisets) and the certified manager and caregivers may administer the medication from the medication organizers as per physician's instruction. Please sign below signifying you are aware of our policies and the orders listed below.

- The certified manager/caregivers will accept physician's order from the resident's physician.
- The certified manager may set up the medication organizer for the above-named resident according to administration policy and procedure.
- The certified manager/caregivers may administer the medication to the resident from the medication organizer according to administration policy and procedure. All prescribed treatment may also be administered by caregivers.

_____ _____

Physician's Signature Date

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APPROVAL OF CONTINUED RESIDENCY

Completed by Doctor (every 6 months)

The Arizona Department of Health Services (ADHS) concerning Licensure of Assisted Living Facilities Rules/ Regulations R9-10-814.B.2.i-iii requires that a facility is unable to accept or retain a resident who is bed bound or wheelchair bound unless:

A manager of an assisted living facility licensed to provide personal care services may accept or retain a resident who is confined to a bed or chair because of an inability to ambulate even with assistance if:

1. The condition is a result of a short-term illness or injury; or
2. The following requirements are met at the onset of the condition or when the resident is accepted by the assisted living facility:
   a) The resident or resident's representative requests that the resident be accepted by or remain in the assisted living facility;
   b) The resident's primary care provider or other medical practitioner:
      i. Examines the resident at the onset of the condition or within 30 calendar days before acceptance and at least once every six months throughout the duration of the resident's condition;
      ii. Reviews the assisted living facility's scope of services; and
      iii. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility;"

Therefore, please complete this form for Resident's Name _____

I, _____ hereby approve to the continued residency of

(Doctor's Name)

_____ who is my patient and whose care requires an increased need

(Resident's Name)

for services or who is bed bound at **CHRISTINA'S ASSISTED LIVING**

facility located at **1423 S. Hazel St. Gilbert AZ 85296**, In lieu of placement

in skilled nursing facility or other acute care facility I hereby authorize care to be given to my patient _____ on _____ (date).

(Resident's Name)

Doctor's Name: _____ Date: _____

Doctor's Signature: _____ Dr's Phone Number: _____