

ASSISTED LIVING PROGRAM MEDICAL EVALUATION – INTERIM

INSTRUCTIONS: This evaluation must be conducted and completed no less frequently than once every 6 months. If additional space is needed, please use the reverse side. **6 Month Reassessment**

Resident Name: _____ **DOB:** _____

Address: _____

*******TO BE COMPLETED BY CHHA, LTHHCP OR LHCSA R.N.*******

1. Describe changes in resident's health or functional status since the last medical evaluation:
2. List current medications (attached medication lists must also be initialed and dated by the resident's physician):
3. Does resident receive skilled services from CHHA or LTHHCP? Yes No
If yes, specify:

Signature/title: _____ **Date:** _____

*******TO BE COMPLETED BY PHYSICIAN*******

1. Changes in resident's diagnosis, health, mental health, diet, allergies, functional or behavioral status, need for assistance and related information since last evaluation.
2. Changes to medication regimen and orders for skilled services; if none, check here

I have examined this resident and this evaluation accurately describes the resident's medical condition, needs and regimens, including any medication regimen. The resident's condition is stable and the individual is medically appropriate to be cared for in an ALP. I certify that I have reviewed and agree with the UAS-NY Assessment dated _____ (if applicable) and that the uniform assessment and the information provided on this form accurately describes the individual's medical and mental health conditions, needs, and regimens, including any medication regimens.

Date of today's examination: _____ **Recommended frequency of medical exams:** _____

Signature/title: _____ **Date:** _____
Nurse Practitioner, Physician's or Specialist's Assistant

Signature/title: _____ **Date:** _____
Physician (required)