DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE
PHYSICIAN ORDERS

Name of ARCH: **Arzaga's Adult Residential Care**

Resident's name:	***Date:***

Diet Order

Type of diet: _____

☐ 4 gram Na or NO Added Salt (NAS) ☐ 2 gram Na

☐NCEP Step 1 ☐NCEP Step II

☐ _____calorie diabetic diet (ADA)

☐Low Fat

☐Other:

Level of Care ☐ Independent Living ☐ ARCH ☐ ICF ☐ SNF

Activity Orders

Ambulation: ☐Ambulatory without Assistance ☐ Walker ☐Cane ☐ W/C

Passes: ☐ May go on a day-pass **without** Supervision for a maximum period of _____ hours
☐ May go on a day-pass **with** Supervision for a maximum period of _____ hours

Restraints: ☐ Seat Belt W/C ☐ Side-rails _____ ☐ Lap Tables ☐ Other: _____

Medications, Vitamins, and Supplements (Please include Drug name, dosage, route, and frequency.)

Other:

_____ _____
Date Physician Name / Signature

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LEVEL OF CARE EVALUATION FOR ADULT RESIDENTIAL CARE HOME RESIDENTS

Resident Name _____ SSN _____

Activities of Daily Living	Need for Verbal Reminders/Encouragement (Level/Points 1)	Need for Some Physical Assistance (Level/Points 2)	Need for Ext./Total Assistance (Level/Points 3)
A. Eating/Feeding	1	2	3
B. Bathing	1	2	3
C. Dressing/Grooming	1	2	3
D. Mobility	1	2	3
E. Transfers	1	2	3
F. Toileting	1	2	3
G. Incontinence-Urine/Feces/Both		1x /Month	2x /Month
(Circle appropriate one)		2	3

Total Circled Level Points _____ = _____ + _____ + _____
(If more than 10 points, reassess in total for ARCH level of care.)

Supervision, Behavior Management	NEED FOR OPERATOR ASSISTANCE / INTERVENTION / CONTROLS		
	Less than weekly but at least 1x / month	At least 4x / month	At least 6x / month
A. Impaired communications	1.5	3	4.5
B. Impaired Judgement	1.5	3	4.5
C. Agitated/Hostile	1.5	3	4.5
D. Hallucinates	1.5	3	4.5
E. Depression	1.5	3	4.5
F. Assaultive/Destructive	1.5	3	4.5
G. Abusive (verbal)	1.5	3	4.5
H. Withdrawn/Regressive	1.5	3	4.5
I. Wanders	1.5	3	4.5
J. Other – Specify _____	1.5	3	4.5

Total Circled Level Points _____ = _____ + _____ + _____
(If more than 5 points, reassess in total for ARCH level of care.)

Health-Related Services — Per doctor's orders	NEED FOR OPERATOR ASSISTANCE		
	1x / day	2-3x / Day	4+ x / Day
A. Oral Medication	1	2	3
B. Non-Oral Medication/Dressing/Treatment	1	2	3
C. Special Diet	1	2	3
D. Medical or Psychiatric Appointments/	1x / Month	2-3x / Month	4+ x / Month
Transportation/Escort Services	1	2	3

Total Circled Level Points _____ = _____ + _____ + _____
(If more than 6 points, reassess in total for ARCH level of care.)

LEVEL OF CARE ASSESSMENT

(See instructions for Form OHCA ARCH N 2)

ADULT RESIDENTIAL CARE HOME LEVEL	**INTERMEDIATE NURSING CARE LEVEL**	**SKILLED NURSING CARE LEVEL**

_____ _____
Signature of Physician/APRN Date

Prepare 1 copy: Original to Primary Care Giver
Copy to Resident/Responsible Person

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SELF PRESERVATION STATEMENT

Name of ARCH Arzaga's Adult Residential Care, LLC

I, _____ certify that
(Print Physician's Name)

_____
(Resident's name)

☐ is ☐ is not ambulatory (*)

He/she ☐ is ☐ is not capable of following directions and taking

appropriate action for self-preservation under emergency conditions.

_____ _____
Physician / APRN Signature Date

_____
Print of type Physician / APRN name

(*) "Ambulatory" means able to walk without human assistance.

HAR, Title 11, Chapter 100.1, mandates that each resident of a Type 1 ARCH must be certified by a physician that the resident is ambulatory and capable of following directions ad taking appropriate and taking appropriate action for self-preservation under emergency conditions [refer to section 11-100.1-23(g)(3)(I)].

DEPARTMENT OF HEALTH
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RESIDENT ADMISSION MEDICAL AND PERSONAL HISTORY

Name: _____ Date of Birth: _____

Address: _____
Number Street City Island Zip Code

Resident's pertinent past history

_____

_____

Height: _____ Weight: _____ B/P: _____

Level of Care Assessment:
The Resident is certified as: ☐**Independent** ☐**ARCH** ☐**ICF** ☐**SNF**

_____ _____

Presents no symptoms, such as skin lesions, respiratory tract symptoms, diarrhea, or other symptoms to indicate the presence of infectious disease which may harm others. YES☐ NO☐

Vision impairment? YES ☐ NO ☐

Hearing impairment? YES ☐ NO ☐

Prescription glasses? YES ☐ NO ☐

Hearing aid? YES ☐ NO ☐

Allergies: _____ Teeth _____ Mouth _____ Throat _____

Circulation/Heart: _____

Respiratory System: _____

GI System: _____

Urinary System: _____

Nervous System: _____

Extremities: arms _____ legs _____

Skin : _____

Diagnoses:

_____

_____

Medications:

_____

_____

_____

Diet: _____

Activities/therapy program:

History of chronic mental illness: Yes ☐ No ☐

If "yes", explain: _____

Is resident being treated for a chronic mental illness? Yes ☐ No ☐

Psychiatric follow-up due _____

Psychiatrist _____ Phone: _____

Medical follow-up due _____

Physician _____ Phone: _____

Any history of violent, destructive behavior or property, or wandering behaviors:

_____

Behavioral modification advised: _____

Patient is physically and mentally capable of following directions and taking appropriate action for self-preservation in the event of fire or other emergency: Yes ☐ No ☐

Immunization history:

Tetanus-diphtheria-toxoid (Booster every 10 years) _____

Pneumococcal vaccine (over 65 years 1x and as needed) _____

Influenza vaccine (over 65 years annually) _____

_____ _____ _____

Physician/APRN Signature Date Phone Number

_____

Print or Type Physician/APRN Name