[ASSISTED LIVING NAME HERE]

[Street Address, City, State, ZIP]

Phone: 123-456-7890 Fax: 123-456-7890

CURRENT MEDICATIONS LIST

When signed by the medical practitioner may be used by the facility as a consolidated Doctor's Order

_______________________________________ DOB: ____________________

(Resident Name)

Allergies: ____

Dear primary care provider:
The information supplied on this form is to enable the Assisted Living Facility in the medication and treatment administration of the above named resident. Please review and return the form with your new or revised orders to assist us in providing care to the resident in our facility.

Reason for Visit: ☐Routine Appointment ☐Complaints (explain):

Current Vitals Signs: Temp: ______ Pulse:______ Resp: ______ BP: ________ Wt: ________

Current Medications: Please write new orders or make changes or comments below.

	Medication Name	Strength	Dose & Instructions	Route
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

X____

Physician Name Signature Date

[ASSISTED LIVING NAME HERE]

[Street Address, City, State, ZIP]

Phone: 123-456-7890 Fax: 123-456-7890

Continued: [Patient Name]

	Medication Name	Strength	Dose & Instructions	Route
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Should we continue medications as listed? ☐ Yes ☐ No

Physician Observations/Notes:

X

Physician Name Signature Date

Please note, MEDICATION – PRESCRIPTION OR NON-PRESCRIPTION – CAN NOT be administered to the patient without a written order specifying medication name, route, strength, and dose instruction

[ASSISTED LIVING NAME HERE]

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INITIAL PHYSICIAN RECOMMENDATION FORM

In order to allow our facility to accept and provide services for

____

(Resident Name)

and be in compliance with Arizona Department of Health Services Rules and Regulations R9-10- Article 8 we are required to have this form reviewed and completed.

Resident is appropriate to receive supervisory, personal, directed level of care, memory care, or behavioral care

Please check ALL that applies:

☐requires hospice services
☐requires intermittent nursing services
☐is confined to a bed or chair (bedbound) or has stage 3 or 4 pressure ulcers- [use form **Determination and Authorization for Continued Residency** in routine forms.]

The individual **does not require or expected to receive** continuous medical services or continuous nursing services and **does not require restraints, including the use of bedrails.**

X____

[Physician, Registered nurse practitioner, Registered nurse, or physician's assistant] Date:

☐**Requires memory care services**

For a resident who requests or receives memory care services from the assisted living facility, a medical practitioner has to [use form **Determination and Authorization for Continued Residency** in routine forms.]:

a. Evaluates the resident within 30 calendar days before acceptance of the resident and at least once every six months throughout the duration of the resident's need for memory care services;
b. Reviews the assisted living facility's scope or services; and
c. 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;

X____

[Medical Practitioner] Date:

☐**Requires behavioral services under the direction of a BHP**

If behavioral health services from the assisted living facility are provided, a behavioral health professional has to [use form **Determination and Authorization for Continued Residency** in routine forms.]:

a. Evaluates the resident within 30 calendar days before acceptance of the resident and at least once every six months throughout the duration of the resident's need for behavioral health services;
b. Reviews the assisted living facility's scope or services;
c. 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;

X____

[Behavioral Health Professional] Date:

[ASSISTED LIVING NAME HERE]

[Street Address, City, State, ZIP]

Phone: 123-456-7890 Fax: 123-456-7890

DETERMINATION AND AUTHORIZATION FOR CONTINUED RESIDENCY
Physician, behavioral health professional, or medical practitioner

____
(Resident Name)

Dear primary care provider: ____
[Physician, behavioral health professional, or other medical practitioner's Name]

The Arizona Department of Health Services requires that the primary care provider or other medical practitioner written authorization to authorize the above named patient to reside or continue the reside in the Assisted Living Facility.

An Assisted Living Facility SHALL NOT ACCEPT OR RETAIN a resident who:

A. Is confined to a bed or chair because of an inability to ambulate even with assistance or
B. Has a stage 3 or 4 pressure sore, as determined by a registered nurse or medical practitioner or
C. Requires or receives behavior care/health service or
D. Requires memory care services

UNLESS APPROVED BELOW:

Please examine the resident and give us, the Assisted Living Facility, your consent and authorization for continuing residency for this resident. This authorization is required at the onset of the above circled condition or within 30 calendar days before acceptance and at least once every six months throughout the duration of the resident's condition, that the facility can meet the resident's needs within the scope or services of the facility.

I am also aware that I must examine this resident every six months and document my authorization as to the continuing residency of my patient at this facility.

This authorization is valid for the next six months from the date signed.

I have also reviewed the assisted living facility's scope of services and 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.

X____
[Physician, behavioral health professional, or other medical practitioner's Name] Date: