ADULT CARE HOME OPERATOR OR RESIDENT MANAGER
Health History and Physician / Nurse Practitioner's Statement

Applicant's Name: _____ Birth Date: / /

Part 1 – Instructions:	**Return Completed Form To:**
1. The applicant is required to complete all of PART 1 (pages 1–2) and give it to your physician/nurse practitioner. 2. The physician or nurse practitioner is required to complete PART 2 (pages 3–5) and send the entire form (pages 1–5) to the ACHP.	Multnomah County Adult Care Home Program 600 NE 8th St., Suite 100 Gresham OR 97030 Fax: 503-988-5722

Current Medical Provider	**Date of last physical exam**
Current provider's name	/ /
Last physician exam by any provider?	/ /

Review of symptoms *(check all that apply)*

Do you have any of the following?		Do you have any of the following?		Have you ever had?	
Weight loss/weight gain	☐	Tiredness or significant fatigue	☐	A car accident	☐
Fevers	☐	Unable to tolerate heat or cold	☐	Loss of consciousness	☐
Headaches	☐	Short of breath with or without exertion	☐	Heart attack	☐
Difficulty with vision	☐	Palpitation or skipped beats	☐	Loss of vision	☐
Dizziness/vertigo	☐	Chest pain or tightness	☐	Abnormal heart rhythm	☐
Seasonal allergies	☐	Indigestion/heartburn	☐	Seizure	☐
Sinus problems	☐	Abdominal pain	☐	Panic attacks	☐
Wheezing	☐	Diarrhea/constipation	☐	Head injury	☐
Cough	☐	Irregular periods	☐	Stroke	☐
Back pain	☐	Frequent urinary tract infections	☐	Paralysis	☐
Joint pain or swelling	☐	Kidney stones	☐	Back injury	☐
History of broken bones	☐	Skin problems (rash, psoriasis)	☐	Psychiatric disorder	☐

Vaccination history/communicable diseases* *(have you had?)*	Yes	No	Unsure
The standard series of childhood vaccinations?	☐	☐	☐
The disease "chicken pox" or the chicken pox vaccine (*Varicella*)?	☐	☐	☐
A tetanus/diphtheria booster shot within the last 10 years?	☐	☐	☐
Hepatitis B vaccination (*this is a series of 3 injections spaced several months apart*)?	☐	☐	☐
The disease "Tuberculosis" (TB)?	☐	☐	☐
A positive tuberculosis test (*also called PPD or Tine Test*)?	☐	☐	☐
Vaccination against tuberculosis with BCG (*this is uncommon in he United States*)?	☐	☐	☐

- http://www.cdc.gov/vaccines/spec-grps/hcw.htm - Healthcare Personnel Vaccination Recommendations

***Current* medical or psychiatric conditions** *(those that you are currently experiencing and/or receiving treatment for, including drug/alcohol abuse)*

	Please list or ☐ N/A	Date of onset		*Please list*	Date of onset
1			2		
3			4		
5			6		

Note: Check N/A (not applicable) if you are not experiencing or receiving treatment for any Medical or Psychiatric

Past medical or psychiatric conditions *(those that you had in the past but recovered from, including drug/alcohol abuse)*

	Please list or ☐ N/A	Date of onset		*Please list*	Date of onset
1			2		
3			4		
5			6		

Note: Check N/A (not applicable) if you have not experienced and/or received treatment for any Medical or Psychiatric condition .

Surgeries/hospitalizations (*list the type of surgery or condition for which you were hospitalized)*

	Please list or ☐ N/A	Date of onset		Please list	Date of onset
1			2		
3			4		
5			6		

Question: When was your last visit to the emergency room?
For what symptom or condition?

Note: Check N/A (not applicable) if you have not had any surgeries or hospitalization or emergency room visits.

Medications/treatments ☐ N/A (*Please include prescription medications, non-prescription medications, vitamins, herbal supplements, medical marijuana and treatments)*

1		2	
3		4	
5		6	
7		8	

Question: *Do you have any allergies to medications or other substances? If yes, please list.*

Note: Check N/A (not applicable) if you are not on any prescription medication, non-prescription medications, vitamins, herbal supplements or medical marijuana or do not have any medication allergies. visits.

Occupational assessment	Yes	No	Unsure
1. Do you have any physical limitations (such as lifting or mobility restrictions) that may limit the type of resident you can care for? If yes, please explain.	☐	☐	☐
2. Do you currently use illicit/illegal drugs? If yes, please explain.	☐	☐	☐
3. How many alcoholic drinks do you consume per day? Per week?	☐	☐	☐
4. Have you ever had an occupational injury/illness before (such as back strain, chemical exposure, or infection due to human blood and body fluid exposure? If yes, please explain.	☐	☐	☐
5. Do you have any condition (physical, medical or psychological) that would require special accommodations in order for you to perform your job? If yes, please explain.	☐	☐	☐

I declare under penalty of perjury that all statements made in this Health History is true and complete. I authorize Multnomah County Adult Care Home Program and my physician, nurse practitioner or clinic to exchange any medical information that is pertinent to my ability to provide care to frail, elderly or disabled adults and operate my adult care home(s). I understand that my failure to provide complete and accurate information may result in the denial of my application or other administrative sanctions against my license or certification.

Applicant's Signature *Date*

PART 2 – must be completed by the applicant's physician or nurse practitioner.
After part 2 is complete, send entire form (pages 1–5) to:
Adult Care Home Program, 600 NE 8th St., Suite 100, Gresham, OR 97030. Fax: 503-988-5722

Applicant's Name: _____ **Exam Date:** ____/____/____
Please print applicant's name

The individual named above is under consideration for a care provider position in an adult care home serving older adults and people with disabilities, or adults receiving behavioral health services. A completed Health History and Physician/ Nurse Practitioner's Statement is required every two years, or more frequently if needed, as a means of documenting that the occupant is in satisfactory health to provide care and services to frail, elderly and disabled adults.

ALL CAREGIVERS including Owner/Operators, Resident Managers and Caregivers must be physically, mentally and emotionally able to care for individuals who may require varying levels of assistance with their Activities of Daily Living.

The job requires physical, mental and emotional health sufficient to perform the following duties safely. This list is not all-inclusive but is provided to give you a sense of the care requirements the above individual will be required to provide.

- Physical activities include changing bedding, mattresses and/or moving furniture in resident rooms; lifting, rotating and assisting residents who are partially or totally incapacitated; providing personal care in eating, dressing, hair and body care, communication, toileting, bathing, oral care, etc.; operating equipment such as wheelchairs, lifting devices, mechanized beds and other related medical devices; medication administration and medical treatments per physician order and under nursing delegation supervision.
- Emotional/mental activities such as being able to patiently listen and provide non-judgmental support and empathy; quick clear thinking; ability to remain calm in an emergency; ability to be able to be assertive and act as a resident advocate; ability to follow rules and procedures directing them on resident care and safety; ability to deal in a supportive and empathetic manner to difficult situations.

Physician/nurse practitioner questions

1. How long have you known this person?
   ☐ Just met today ☐ Months Years ☐Other (describe below)

2. What information did you review to complete this Health History Assessment (*check all that apply)*
   ☐ Interview – date occurred: / /
   ☐ Physical exam – date occurred: / /
   ☐ Medical record review including mental health and addiction treatment
   Specify the information reviewed:

   ☐ Diagnostic testing and studies
   Specify the information reviewed:

3. Please rate the applicant's ability to:	Unknown	Poor	Average	Good
Lift over 50 pounds on a regular/daily basis	☐	☐	☐	☐
Cope with high levels of stress on a daily basis	☐	☐	☐	☐
Stand for long period of time	☐	☐	☐	☐
Communicate verbally with medical personnel	☐	☐	☐	☐
Follow instructions	☐	☐	☐	☐

4. In your assessment have you identified any physical conditions or impairments that would limit this person's ability to care for, life or physically support the movement of heavy, frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below:**

5. This person has listed their current medication(s)/treatment(s) on page 2 of this document. After your review of that medication/treatment list, have you identified any issues that might reduce this individual's capacity to safely care for frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below:**

6. Based on your health assessment and review of the applicant's health inventory, does this person have any mental or emotional problems that might hinder his ability to care for frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below:**

7. Based on your health assessment and review of the applicant's health inventory, does this person have any cognitive problems that might hinder his ability to care for frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below:**

8. Are there any indications this person ever abused drugs or alcohol?
☐ No ☐ Yes **If yes, please explain below and include treatment received, if any:**

9. In your opinion, would this applicant benefit from any evaluation and/or monitoring in either of the following area?
Physical health concerns ☐ No ☐ Yes Mental/emotional health concerns ☐ No ☐ Yes
If yes, please explain:

10. Do you have any concern that have not been addressed in this form?
☐ No ☐ Yes **If yes, please explain below:**

Thank you for completing this form. Your assessment and statement are used to ensure resident and caregiver safety in Adult Care Home settings

Physician/Nurse Practitioner Attestation and Signature

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omissions, or concealment of material fact may subject me to administrative, civil or criminal liability.

Signature and credentials of physician or nurse practitioner	*Date*	*Phone Number*

Please note: Signature stamps are not accepted
Printed name of physician or nurse practitioner:
Address and phone number: