clare housing
HOME • HEALTH • HOPE

Clare Housing Care Home Application Part B. This part of the application must be filled out by applicant's infection disease or primary provider.

PLEASE EMAIL COMPLETED Applications to: HousingApplicant@clarehousing.org
OR FAX TO:612 236 9520

Date of Application**:** _____ Applicant name: _____ DOB:_____

Provider Name: _____ Clinic name: _____ Phone/Fax :_____

Applicant Basic Health Profile:

Allergies (please provide rxn if known): _____

Height: _____ Current Weight: _____ Any major weight losses or gains in the last year, if yes explain _____

Special diet:_____

Please provide copy of immunization record.

Date of last hospitalization and reason:

_____

_____

HIV Health:

Date of HIV infection: _____ Date of AIDS diagnosis: _____

Current viral load (please provide date): _____ Current CD4 count:_____

Physical Health and/or Treatments:

Does the applicant use adaptive equipment, if so, please list (walker, wheelchair etc.)

_____

_____

Does the applicant have: ☐Dentures ☐Corrective lens ☐Hearing Aid

Does the applicant have any existing ports or catheters? _____

Is the applicant receiving any of the following treatments or therapies:

☐Dialysis
☐Tube Feeding
☐Supplemental Oxygen
☐CPAP
☐BIPAP
☐Cough Assist
☐Ostomy care
☐Catheter care
☐Wound care
☐Physical Therapy
☐Occupation Therapy
☐Speech Therapy
☐IV Fluids
☐IV medication
☐IV site care
☐Blood Transfusions

1. APPLICANT'S MEDICAL HISTORY

Please provide a list of diagnoses with ICD 10 codes

Any recent health issues

_____

_____

Does the applicant have a history of **mental health issues** ? If yes, please describe:

_____

_____

When did the applicant last **use substances** (meth, crack, marijuana, heroin, opioids etc)? If so, what substances, please describe:

_____

_____

Systems overview

CARDIOVASCULAR

☐ No Problems

☐ Chest Pain
☐ Palpitations
☐ Edema
☐ SOB

☐ Hypertension
☐ Pacemaker
☐ Anemia

RESPIRATORY
☐No Problems
☐ Shortness of Breath with:
____rest ____Activity
☐Wheezing
☐Cough - TYPE:
____Dry ____Productive
☐ Smoker
☐ Asthma

COMMENTS:
_____
_____
_____

URINARY
☐ No Problems
☐ Hesitancy when urinating
☐ Frequency urination
☐ Bladder infections
☐ Dribbling of urine
☐ Urine incontinence

COMMENTS:
_____
_____
_____

ENDOCRINE
☐No Problems
☐Excessive thirst
☐Excessive hunger
☐Heat or Cold Intolerance
☐Thyroid
☐Diabetes
☐Other

COMMENTS:
_____
_____
_____

COMMENTS:
_____
_____
_____

NEUROLOGICAL
☐No Problems
☐ Balance
☐ Fainting/dizziness
☐ Seizures
☐ Tremors
☐ Falls

☐ Gait imbalances
☐ CVAs
☐ Paralysis
☐ Other

GASTROINTESTINAL
☐ No Problems
☐ Difficulty swallowing
COMMENTS:
_____

☐ Bowel incontinence
☐ Other
☐ Belching
☐ Abdominal pain
☐ Hemorrhoids
☐ N/V
☐ Ulcers
☐ Constipation
☐ Heart burn

COMMENTS: Click or tap here to enter text.

MUSCULOSKELETAL
☐ No Problems
☐ Stiffness
☐ Weakness
☐ Cramps
☐ Back Pain
☐ Joint Problems
☐ Amputation
☐ Other

COMMENTS: Click or tap here to enter text.

SKIN
☐ No Problems
☐ Rashes
☐ Statis ulcers
☐ Dryness
☐ Itching
☐ Decubitus ulcer
☐ Other

COMMENTS: Click or tap here to enter text.

What other providers, treatment or counseling is applicant receiving?
☐ Psychiatry
☐ Psychotherapy
☐ Addiction medicine/chemical health counseling

☐ Neurology
☐ Endocrinology
☐ Dermatology
☐ Opthamology
☐ Cardiology
☐ Pulmonology
☐ Orthopedics
☐ Physical therapy
☐ Urology
☐ Gynecology
☐ Oncology
☐ Gastroenterology
☐ Nephrology
☐ Podiatry
☐ Other:

Does the applicant keep scheduled appointments? ☐ Yes ☐No

In your opinion, is the applicant functionally impaired? ☐ Yes ☐No
Functionally impaired means a person who has:

- Substantial difficulty carrying out one or more of the essential major activities of daily living, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working; or
- A disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

Do you have any concerns about the applicant's ability to drive a car safely? □ Yes □No
Will you continue to provide medical care to the applicant if the applicant moves into the care homes?

Clare Care Homes operates under 245D license which does not require nursing oversight, if this applicant becomes a resident of adult foster care, does the staff after training from you or by registered agency (such as Health Counseling Services) have your permission to administer medications?

☐ Yes ☐No ☐ Yes, with exceptions (If SQ injections are on medication list then a separate injection form must be signed for) _____

Any additional comments that would assist in planning care for this applicant? _____

_____

On the basis of my examination, it is my finding that the above-named applicant does not have any condition communicable disease or otherwise that might endanger foster care home residents.

Providers Signature _____ Date _____