

NOTICE OF FORM CHANGE NO. 04-316DATE
12/10/2004**TO:**
County Welfare Director
Supply Clerk / Forms Coordinator**FROM:**
Forms Management Unit
(916) 657-1907 Community Care Licensing District Offices
 Private and Public Adoption Agencies District Attorney
 Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE LIC 602A (12/04) Physician's Report For Residential Care Facilities For The Elderly (RCFE)

ORDER UNIT MASTER ONLY	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 12/04	REPLACES 10/01	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input checked="" type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788		<input type="checkbox"/> Other:	

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY

 Use until exhausted Destroy

USE NEW FORM

 When supply available in DSS Warehouse Use new form effective immediately.

USE FORM IN ACCORDANCE WITH

 All County Letter No.
 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

6 page, 8-1/2" x 11" form.

Check on the internet to see if forms are available at www.dss.cahwnet.govFor camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)**I. FACILITY INFORMATION** *(To be completed by the licensee/designee)*

1. NAME OF FACILITY		2. TELEPHONE ()	
3. ADDRESS		CITY	ZIP CODE
4. LICENSEE'S NAME	5. TELEPHONE ()	6. FACILITY LICENSE NUMBER	

II. RESIDENT/PATIENT INFORMATION *(To be completed by the resident/resident's responsible person)*

1. NAME	2. BIRTH DATE	3. AGE
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III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION*(To be completed by resident/resident's legal representative)*

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS	3. DATE
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IV. PATIENT'S DIAGNOSIS *(To be completed by the physician)*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered.

(Please attach separate pages if needed.)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE
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6. TUBERCULOSIS (TB) TEST

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
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e. Results: mm _____ f. Action Taken (if positive): _____

g. Chest X-ray Results: _____

h. Please Check One of the Following:

 Active TB Disease Latent TB Infection No Evidence of TB Infection or Disease

7. PRIMARY DIAGNOSIS:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

- Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a “conditional state” between normal aging and dementia.
- Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

11. ALLERGIES:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (If applicable)	EXPLAIN
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use of Alcohol				
h. Use of Cigarettes				
i. Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment/Paralysis				
l. Requires Continuous Bed Care				
m. History of Skin Condition or Breakdown				

14. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented			
b. Inappropriate Behavior			
c. Aggressive Behavior			
d. Wandering Behavior			
e. Sundowning Behavior			
f. Able to Follow Instructions			
g. Depressed			
h. Suicidal/Self-Abuse			
i. Able to Communicate Needs			
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items			
k. Able to Leave Facility Unassisted			
15. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self			
b. Able to Dress/Groom Self			
c. Able to Feed Self			
d. Able to Care for Own Toileting Needs			
e. Able to Manage Own Cash Resources			
16. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Administer Own Prescription Medications			
b. Able to Administer Own Injections			
c. Able to Perform Own Glucose Testing			
d. Able to Administer Own PRN Medications			
e. Able to Administer Own Oxygen			
f. Able to Store Own Medications			

17. AMBULATORY STATUS:

- a. This person is considered: Ambulatory Nonambulatory Bedridden

Nonambulatory: Means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. (Health & Safety Code Section 13131)

Bedridden: Means either requiring assistance in turning and repositioning in bed, or being unable to independently transfer to and from bed, except in facilities with appropriate and sufficient care staff, mechanical devices if necessary, and safety precautions. No resident shall be admitted or retained in a residential care facility for the elderly if the resident is bedridden, other than for a temporary illness or for recovery from surgery. (Health & Safety Code Section 1569.72)

- b. If resident is nonambulatory, this status is based upon:

- Physical Condition Mental Condition Both Physical and Mental Condition

- c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

- Illness: _____
- Recovery from Surgery: _____
- Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

- d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____ (number of days)
2. _____ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)
3. If illness or recovery is permanent, please explain: _____
- _____
- _____
- _____

- e. Is resident receiving hospice care?

- No Yes If yes, specify the terminal illness: _____

18. PHYSICAL HEALTH STATUS: Good Fair Poor

19. COMMENTS:

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE
()

22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT

23. PHYSICIAN'S SIGNATURE

24. DATE