HEALTH CARE APPRAISAL

Michi	gan Departmen	it of Licensing a			<u>, Bureau of Commur</u>			ms	
Licensee Name Resident			Resident Name	ame			Case Number		
AFC Facility Name Facility Lic			Facility License	ense Number Worker Name / Load Number		Worker Pt	Worker Phone Number		
the responsible agend	cy, and the Michigan De _l	partment of Licensing an	lerstand that I and I American I am	m authorizing the r fairs, Bureau of Co	l elease of medical information c Immunity and Health Systems fo	oncerning me to or the purpose of	o the licensee and of providing approp	licensee's staff, riate care to me	
and determining com Signature of Resident	pliance with licensing ru :/ Legal Guardian	les		Title	W.C		Date		
				1.1.0					
Release of HIV/AIDS in	formation: By signing thi	s form, I understand that I	am authorizing th	e release of medica	al information concerning me, inclu	ding information	regarding Acquired	Immunodeficiency	
Syndrome (AIDS), or Hu Bureau of Community	ıman Immunodeficiency Vii and Health Svstems, fo	rus (HIV), if applicable, to the three purpose of providing a	ne licensee and lice	ensee's staff, the re-	sponsible agency, and the Michigan g compliance with licensing rules.	n Department o	f Licensing and Re	egulatory Affairs,	
Signature of Resident / Legal Guardian					g complete the transfer of the		Date		
1. Height	2. Weight 3. Ideal Weight Range		4. Blood P	4. Blood Pressure		6. Sex	FEMALE		
7. Diagnoses	L			15. Physic	al Exam:		/	7	
					TYPE	NORM	A ABN	DEFERRED	
				1. Skin		110111	ADIN	/ DEFENNEL	
8. Current Medications	s and Instructions			2. Ears					
					- 3. Nose				
				4. Thro	at				
				5. Mout	h				
				6. Neck					
				7. Brea	sts				
				8. Ches	st				
				— 9. Lung	s				
				10. Hear	· · · · · · · · · · · · · · · · · · ·				
				11. Abdo					
9. Allergies				12. Extre	· · · · · · · · · · · · · · · · · · ·				
					Lower				
				13. Feet					
10. General Appearance				14. Lymp 15. Geni					
				16. Teste	·				
					17. Spine				
11. Mental / Physical Status and Limitations					18. Reflexes			 	
				19. Neur				 	
40. 14-1-19:- / 41-1-1-1-1	01-1			20. Rect					
12. Mobility / Ambulatory Status: Fully Ambulatory					ally Transmitted Diseases		ES [NO	
Uses Cane Uses Wheelchair				22. Othe	22. Other:				
13. Susceptibility to Hyper / Hypothermia and Related Limitations									
Tot oddooptiomty to th	, por r r r positor r ma aria	Tiolatoo Emiliations							
				**Deferred	**Deferred, as used here, means examination considered but postponed				
				Explanatio	n of Abnormalities/Treatment O	rdered			
14 Consid Distancia	htrustians and December	anded Calculated							
14. Special Dietary Instructions and Recommended Caloric Intake									
16. Other Health-Rela	ited Information or Cond	erns		<u>I</u>					
							······································		
M.D./D.O./P.A. or R.N	N. (Please Print Name)							
Signature				City		State	Zip Code		
Address	ddress Title			Date of S	ignature	Date of Exam			
AUTHORITY: 1979 PA	A 218	R 400.14301(10) and R 4	00,15301(10)						
COMPLETION: Required. R 400.14310 and R 400.15310 CONSEQUENCE: Violation of AFC Licensing Rules. R 400.14313(3) and R 400.15313(3)					LARA is an equal opportunity employer/program.				

BCAL-3947 (Rev. 1-16) Previous editions may be used.