DHS Oregon Department of Human Services

AFH-DD Health History and Physician/Nurse Practitioner's Statement

Applicant's name: _____ **Birth date:** ___/___/___

PART 1 – Instructions:
1. **The applicant is required to complete all of PART 1.** *(Pages 1-2)*
2. **The physician or nurse practitioner is required to complete PART 2.** *(Pages 3-4)*

Return completed form to:
Attn: DD Foster Care Licensor
Washington Co. DD Program
155 N. First Ave. MS-66
Hillsboro, OR 97124

Current medical provider **Date of last physical exam**

Current provider's name: ___/___/___

Last physical exam by any medical 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 the 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 receiving treatment for)*

	Please list ☐ 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 condition.

Past medical or psychiatric conditions (Those that you have had in the past but recovered from)

	Please list ☐ 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 had experienced and/or received treatment for any Medical or Psychiatric condition.

Surgeries/hospitalizations (List type of surgery or condition for which you were hospitalized)

	Please list ☐ N/A	Date		*Please list*	Date
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 visit.

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 medication prescription, non-prescription medications, vitamins, herbal supplements or medical marijuana or do not have any medication allergies.

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/client you can care for? *(If yes explain)*	☐	☐	☐
2. Do you currently use illicit/illegal drugs? *(If yes explain)*	☐	☐	☐
3. How many alcoholic drinks do you consume per day? Per Week?	☐	☐	☐
4. Have you ever had an occupational injury/illness before (back strain, chemical exposure, or infection due to human blood and body fluid exposure)? *(If yes 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 explain)*	☐	☐	☐

I declare under penalty of perjury that all statements made in this Health History are true and complete. I authorize the Department of Human Services' Developmentally Disabled Adult Foster Home Licensing Unit and my physician, nurse practitioner or clinic to exchange any medical information that is pertinent to my ability to provide care to the frail, elderly or disabled adults and operate my adult foster home(s). I understand that my failure to provide accurate and complete information may result in the denial of my application or other administrative sanctions against my DD adult foster home license.

Applicant's signature _____ *Date* _____

PART 2 – TO BE COMPLETED BY APPLICANT'S PHYSICIAN OR NURSE PRACTITIONER

Applicant's name: _____ **Exam date:** ___/___/___
Please print applicant's name

The individual named above is under consideration for a care provider position in a Developmentally Disabled adult foster home. A completed Health History and Physician/Nurse Practitioner's Statement is required every three years, or more frequently if needed, as a means of documenting that the applicant is in satisfactory health to provide care and services to frail, elderly and disabled adults.

ALL CAREGIVERS, whether they are owners of a DD adult foster home, resident managers or shift 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 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 device; medication administration and medical treatments per physician order and under nursing delegation supervision.
- Emotional/mental activities being able to patiently listen and provide non-judgmental support and empathy, quick clear thinking and can remain calm in an emergency, able to be assertive and act as a resident advocate, able to follow rules and procedures directing them on the resident care and safety and able 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 – please be specific
☐ Diagnostic testing and studies – please be specific

3 In your assessment have you identified any physical conditions or impairments that would limit this person's ability to care for, lift or physically support the movement of heavy, frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below and include what information and/or documentation you relied on.**

4 This person 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.**

5 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/her ability to 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 cognitive problems that might hinder his/her ability to care for frail, elderly or disabled adults?

☐ No ☐ Yes **If yes, please explain below.**

7 Are there any indications this person ever abused drugs or alcohol?

☐ No ☐ Yes **If yes, please explain below and include treatment received if any.**

8 In your opinion, would this applicant benefit from any evaluation and/or monitoring in either of the following areas:

Physical health concerns ☐ No ☐ Yes Mental/emotional health concerns ☐ No ☐ Yes

If yes, please explain below.

9 Do you have any concerns 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 the DD Adult Foster Home setting.

Physician 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: