

**STATE OF GEORGIA
PERSONAL CARE HOME PHYSICIAN'S REPORT**

Part 2/2

Name: _____

CIRCLE THE APPROPRIATE ANSWER IN EACH STATEMENT BELOW

- 1 The individual **HAS / HAS NOT** received screening for TB and **HAS / DOES NOT HAVE** signs and/or symptoms of infectious diseases which are likely to be transmitted to other residents or staff.

TB SCREENING INFORMATION: Date: _____ Results: _____
- 2 The individual's behavior **DOES / DOES NOT** pose a danger to self or others. If **DOES**, please explain. If medications are necessary to control behavior, please explain: _____

- 3 The individual **DOES / DOES NOT** require assistance from staff during the night. If **DOES**, please explain:

- 4 The individual **DOES / DOES NOT** require 24 hour nursing supervision.
- 5 **Based on the type of care the staff of Personal Care Homes may legally provide, the individual's needs CAN / CAN NOT be met in a Personal Care Home for adults that is not a medical or nursing facility.**

COMMENTS

TYPED NAME OF EXAMINER			GEORGIA LICENSE
ADDRESS OF EXAMINER			CITY
STATE	ZIP	TELEPHONE	DATE
SIGNATURE OF EXAMINER			

PLEASE RETURN COMPLETED FORM TO FACILITY

PROVIDENCE HOUSE ASSISTED LIVING, LLC

ADDRESS	CITY	STATE	ZIP
12775 Providence Road	Alpharetta	GA	30004
CONTACT PERSON		TELEPHONE	FAX
Laurey Sherman		(404) 824-1008	(770) 410-9491