

c. The individual **DOES** **DOES NOT** require assistance from staff during the night. If assistance is required, please explain.

d. The individual **DOES** **DOES NOT** require 24 hour nursing supervision.

e. The individual **DOES** **DOES NOT** require placement in a specialized memory care unit (unit with controlled access/egress designed to serve residents who are at risk of engaging in unsafe wandering activities or other unsafe behaviors).

10. **MEDICATIONS:** List all medications including over the counter medications, herbal remedies, topical medications, vitamins, etc. Any PRN medications must include instructions, i.e. parameters for use.

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE	NEEDS HELP WITH ADMINISTRATION	
				YES	NO

MEDICAL CERTIFICATION SIGNATURE REQUIRED.

Assisted living facilities/personal care homes **ARE NOT permitted** under the law to provide medical, skilled nursing or psychiatric care. In your professional opinion, can this patient's needs be safely met in an assisted living facility/personal care home? YES: _____ NO: _____

COMMENTS:

SIGNATURE OF PHYSICIAN, PA OR NP:	DATE:
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PRINTED NAME OF PHYSICIAN, PA OR NP	GEORGIA LICENSE #
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ADDRESS OF PHYSICIAN, PA OR NP

CITY	STATE	ZIP CODE
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PLEASE RETURN COMPLETED FORM TO:

CONTACT PERSON	FACILITY NAME
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ADDRESS	PHONE:
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CITY	STATE	ZIP CODE
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