BOULEVARD ALP
ASSISTED LIVING

Mental Health Evaluation

Name of Resident:	

The above-named resident does not evidence need for placement in a residential treatment facility licensed or operated pursuant to article 19, 23,29 or 31 for mental health hygiene law.

1. I have examined _____ on _____
   (Name) (Date)

2. The above resident is mentally suited for care in an Enriched Housing Program? Yes □ No □

3. Is the resident a danger to him/herself or others? Yes □ No □

4. Please list any psychiatric medications prescribed to the above-named resident at this time. Please include dosages:

_____

_____

_____

5. Please list all significant mental health issues or present conditions, including diagnosis, which should be considered by the Enriched Housing Program in order to provide adequate service to the resident.

_____

_____

_____

PHYSICIAN STAMP HERE:

Physician's Signature		Date:	
Print Physician's Name:			
Telephone Number:			
Address:			