



PHYSICIAN'S STATEMENT

Patient Name: _____ Gender: M F DOB: _____

Home Address: _____

Date of most recent physical examination: _____

Allergies: _____

Diagnosis(es), ACTIVE medical problems:

Has the Applicant had any of the following diseases or disorders? Please circle no or yes. If yes, please provide any additional information, which will aid in our service planning for the Applicant.

Heart Disease: No Yes _____ Infarcts: No Yes _____

Angina: No Yes _____ Stroke: No Yes _____

Emphysema: No Yes _____ Paralysis: No Yes _____

Diabetes: No Yes _____ Epilepsy: No Yes _____

Cancer: No Yes _____ Hip Fracture(s): No Yes _____

Urinary Problems: No Yes _____ Incontinence: No Yes _____

Hernias: No Yes _____ Arthritis: No Yes _____

Allergies: No Yes _____ Skin Conditions: No Yes _____

Hemorrhages No Yes _____ Aphasia: No Yes _____

Pertinent INACTIVE medical problems, medical history:

History of cognitive difficulties and psychosocial issues including the presence of disruptive behaviors or behaviors which may present a risk to the health and safety of the resident or others:

Treatments (specific orders and frequency); special needs:

Diet: _____

Physical Exam data:

Weight _____

Height _____

Blood Pressure _____

S/A _____

Temperature _____

Mantoux : Yes / No Date of last test: _____

Chest X-Ray _____

Other _____

Please describe any sensory impairments:

Visual: _____

Hearing: _____

Speech: _____

Please check the appropriate status for each of the following:

1. Medication Monitoring

- complete self-management and self-administration of all medication
- needs only supervision and some assistance to self-administer
- needs only supervision to self-administer
- needs administration by licensed personnel

2. Eating

- fully independent
- needs supervision
- needs assistance

3. Nutrition Management & Compliance

- fully independent
- needs supervision
- needs assistance

4. Dressing

- fully independent
- needs supervision
- needs assistance

5. Grooming

- fully independent
- needs supervision
- needs assistance

6. Bathing

- fully independent
- needs supervision
- needs assistance

7. Toileting

- fully independent
- needs supervision
- needs assistance

8. Ambulation

- fully independent
- needs supervision
- needs assistance

9. Transferring

- fully independent
- needs supervision
- needs assistance

Will the Applicant need any of the following appliances or durable medical equipment?

Walker: No / Yes Cane: No / Yes Wheelchair: No / Yes

Other Equipment (Please specify): _____

Please identify any other special needs the Applicant may have and suggest how they might be accommodated:

I approve of _____'s residency in assisted living.

Physician Signature: _____

Physician Name: _____

Address: _____

Telephone: _____ Fax: _____

Date: _____

Patient's Name _____

Start Date	Medication Dosage, Method of Administration, and Frequency Please include appropriate time of day for each medication.	Notes

Physician Signature _____

Physician Name: _____

Address: _____