SCANDINAVIAN
LIVING CENTER

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: _____

Strength Training Program
Physician Consent Form

Participant Name: _____

Date of Birth: _____ Telephone: _____

Dear Doctor,

Our resident has applied to participate in the Strength Training Program at the Scandinavian Living Center. Upon entering the program, the staff will determine an appropriate exercise program. Staff will supervise the participant to appropriately use weight training equipment. If you have any questions, please call our Fitness Instructor, at (617) 527-6566. You may return this form to Alexandra Mahar by mail: 206 Waltham Street, West Newton, MA, 02465 or fax: (617) 527-2078. Thank you. **This form must be filled out in order to participate in any fitness programs.

Relevant Medical Conditions:_____

Relevant Medications: _____

Precautions, Restrictions or Recommendations: _____

_____

_____

Please circle YES or NO

This individual may participate in:

Supervised use of Strength Training Program: Keiser equipment	YES	NO
Unsupervised use of Strength Training Program: Keiser equipment	YES	NO
Supervised use or cardiovascular equipment: Nu-step	YES	NO
Unsupervised use or cardiovascular equipment: Nu-step	YES	NO

Referring physician (please print): _____

Telephone: _____

Address: _____

Physician Signature: _____ Date: _____

Patient's Name _____

Please fill out or attach a current, signed medication list.

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

Physician Signature _____

Physician Name: _____

Address: _____

Telephone: _____ Fax: _____

Date: _____