PHYSICIAN'S MEDICAL STATEMENT AND REPORT

Patient's Name: ____ **DOB:**_________________________

Date of physical examination (date must be within 30 days PRIOR to move in): ______________________

Code Status (please attach Rx and signed form if DNR): ______________________

1. Current Diagnosis:
2. Physical Limitations:
3. Mental Health Limitations:
4. Treatment/Therapies (Describe medical service or nursing care needed. Attach a prescription.)
5. Supportive Services Needed:
6. Allergies:

Please attach current prescriptions your patient is receiving so we may order the correct medications. **Also include any PRN or OTC medications** they are taking as we are unable to allow any medications without written physician prescriptions in assisted living.

MEDICATION	DOSE	ROUTE	TIME TO BE GIVEN

DIET INSTRUCTIONS: ____ Regular Diet ___ No Added Salt ___ Low Concentrated Sweets

____ Pureed ____ Mechanical Soft, Chopped ____ No Fried Foods

STATUS OF THE FOLLOWING:

AMBULATING	BATHING	DRESSING	EATING
__Independent	__Independent	__Independent	__Independent
__Needs supervision	__Needs reminders	__Needs reminders	__Needs prompting
__Hands on assist	__Monitor/Supervise/Cue	__Lay out articles	__Minimal assistance
__Uses cane/walker/wheelchair	__Set up for bathing	__Minor assist (buttons, laces)	__Finger foods/Cut
__Needs assistance transferring	__Assist in/out of shower	__Full assistance needed	__Spoon fed
	__Assist with certain areas		
	__Full assistance needed		

Patient's Name: ____

GROOMING	**TOILETING**	**MOBILITY**	**MEDICATION**
__Independent	__Independent	__Independent	__Self Medicates
__Needs reminders/cues	__Needs reminders/cues	__Needs Supervision	__ Staff administer meds
__Set up for grooming	__Incontinent with self-care	__Needs Assist of 1	
__Full assistance	__Incontinent/total assistance	__Uses walker	
		__Uses wheelchair	

Please read carefully and initial each of the following ONLY IF APPROPRIATE:

_______ The individual's behavior does **not** pose a danger to self or others.

_______ The individual **DOES NOT** need 24 hour RN or LPN supervision (as in a skilled nursing home or hospital).

_______ Based on the type of care the staff of an Assisted Living may legally provide, the **individual's needs can be met in an Assisted Living Community** for adults that is not a skilled nursing home.

_______ The individual is free from signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact.

_______ Considering the cognitive limitations, it is my opinion that this individual requires a **secured (locked) dementia** care unit.

_______ The individual is able to safely maintain and control the security of common household cleaning chemicals and personal grooming supplies in his/her own room.

_______ The individual is able to safely maintain over-the-counter medications in his/her own room and may self medicate OTC's at their own discretion.

_______ The individual is able to participate in supervised food preparation activities at will.

_______ The individual is able to make food choices outside of any diet order/restrictions.

STATE REQUIREMENT FOR ADMISSION TO ASSISTED LIVING COMMUNITY:

Date 1st step PPD given: ________Date 1st step PPD read: _________Results of 1st step PPD: __________mm.

2nd step may be given at the Heritage at Lowman if admitted within 21 days from the 1st step. If not admitted, then 2nd step must be given at physician's office within 7-21 days of 1st step.

Date 2nd step PPD given: ________Date 2nd step PPD read: _________Results of 2nd step PPD: __________mm.

X-Ray results if resident known positive: ___________________________(Attach report as necessary).

I understand that assisted living residences are built in accordance with modern life safety and disability construction codes and fire protection requirements. In my opinion, this individual is capable of self-preservation with minimal human assistance (no more than 1 person) in an emergency involving the immediate evacuation of the facility.

Physician's Printed Name:____

Physician Signature: ____

Address: ____

Telephone: ______________________ **Fax:** ________________**Date Signed:** ________________________