the Heritage at Lowman
Lutheran Homes of South Carolina

Medical Certificate

Please check the area of Lowman for which you are making application:

Rehab and Healthcare Center (Skilled Nursing) __X__
Assisted Living _____
Special Care Unit (Assisted Living Dementia Care) _____

This medical certificate is to be completed by the Family Physician

Name of Applicant: _____
Address: _____
_____
Date of Birth: _____

I have known the applicant for ____ years and submit the following information as to his/her past and current mental and physical condition.

Date of last Examination: _____
Height: _____
Weight: _____
Temperature: _____
Blood Pressure: _____
Allergies: _____

Urinalysis:
SP Gravity _____ Reaction: _____
Albumin: _____ Sugar: _____
Microscopic: _____

Indicate if the applicant has any history of the following:

- Tuberculosis Date: _____
- Paralysis Date: _____
- Urinary Retention Date: _____
- Prostatic Hypertrophy Date: _____
- Cancer Type: _____ Date: _____
- Fractures Type: _____ Date: _____
- Diabetes: Age of Onset: _____

Please indicate if there are any problems in the following areas and specify on the lines provided:

- Eyesight _____
- Incontinency of bowel or bladder _____
- Asthma _____
- Skin Conditions _____
- Hernia _____
- Throat (Swallowing) _____
- Abdomen (Masses, tenderness) _____
- Circulation _____
- Hearing _____
- Kidneys/Bladder _____
- Arthritis _____
- Hemorrhages _____
- Mouth _____
- Neck _____
- Rectum/Pelvic _____
- Seizures _____

Please indicate recommended diet for applicant:

- Regular Diet
- No Concentrated Sweets
- No Added Salt
- Special Consistency, please specify: _____
- Other dietary needs, please specify: _____

Vaccinations:

- Pneumococcal Date Given: _____
- Influenza Date Given: _____
- Tetanus Date Given: _____

PPD (TB Test):

Date Given: _____ Date Read: _____Results: _____MM: _____
Date Given: _____ Date Read: _____ Results: _____MM: _____

If positive reaction, please provide chest x-ray results:

_____
_____

Mobility:

- Ambulates independently
- Ambulates with walker or cane
- Ambulates with walker and physical assistance
- Uses wheelchair occasionally
- Uses wheelchair all or most of the time
- Is able to independently transfer self from sitting to standing position
- Needs assistance to transfer from sitting to standing position.

Please indicate any special instructions regarding ambulation or transferring:

_____
_____

Additional Medical History

Please describe any current or past mental illness or disease and indicate treatment: _____

Describe in detail if there is any history of substance abuse or dependence:

_____

Does the applicant have any communicable diseases? Yes ____ No ____
If Yes, please describe: _____

I have observed and determined that the applicant is able to administer his/her own medications. Yes _____ No _____

The applicant requires 24-hour nursing care in a licensed Skilled Nursing Facility. Yes _____ No _____

Please list all medications prescribed:

_____
_____
_____
_____
_____
_____
_____
_____

Primary Diagnosis:

_____

Secondary Diagnosis - Please include all:

_____
_____
_____
_____
_____

- I will be the attending physician for the applicant while in the facility
- I will not be the attending physician for the applicant while in the facility.

_____ _____

Signature of Physician Date

Please print physician name, address, and phone number.

_____
_____
_____
_____