PHYSICIAN'S MEDICAL STATEMENT AND REPORT

the Heritage at Lowman
Lutheran Homes of South Carolina

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
___Independent
___Needs supervision
___Hands on assist
___Uses cane/walker/wheelchair
___Needs assistance transferring

BATHING
___Independent
___Needs reminders
___Monitor/Supervise/Cue
___Set up for bathing
___Assist in/out of shower
___Assist with certain areas
___Full assistance needed

DRESSING
___Independent
___Needs reminders
___Lay out articles
___Minor assist (buttons, laces)
___Full assistance needed

EATING
___Independent
___Needs prompting
___Minimal assistance
___Finger foods/Cut
___Spoon fed

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:

PLEASE NOTE: PERSON PLACING PPD MUST BE LICENSED MEDICAL PROFESSIONAL – LPN, RN, NP, PA, or MD

Date 1st step PPD given: _____ Date 1st step PPD read: _____ Results of 1st step PPD: _____mm.
LOT #:_____ Exp. Date:_____ Person Placing PPD: _____ Person Reading PPD: _____

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.
LOT #:_____ Exp. Date:_____ Person Placing PPD: _____ Person Reading PPD: _____

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: _____