PHYSICIAN'S REPORT FOR ASSISTED LIVING HOME

FOR RESIDENT / CLIENT OF, OR APPLICANT FOR ADMISSION TO, HOME CARE FACILITIES

688 S. Garland Prairie Rd Williams, AZ 86046

Our Facilities Main Office: Phone: (928) 635-6750 Fax: (928) 635-6751

The Pines: (928) 526-1876

Pine Meadows Ranch: (928) 522-8622 Download this form at www.FlagstaffCareHomes.com

NOTES TO PHYSICIAN:

- -The person specified below is a resident / client of or an applicant to a licensed Assisted Living Home
- -These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents / clients.
- THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
- The information that you complete on this person is required to assist in determining whether he/she is appropriate for admission to or continued care in our facilities. We will also use this information to help us give them the best daily care within our power.

RESIDENT / CLIENT INFORMATION

Name					Date of Birth		Social Security Number
Street Adda	ress		City	S	tate	Zip	Telephone
	AUTHORIZED FOR RELEASE OF MEDICAL INFORMATION (To be completed by person's authorized representative) I hereby authorize the release of medical information contained in this report regarding the physical examination of:						
Patient Nar	me						
To (Name a	To (Name and Address of Licensing Agency)						
Signature of Resident/Potential Resident and/or His/Her Authorized Representatives							
PATIF	ENT'S D	IAGNO	SIS (To be o	complet	ed by th	e Phy	vsician)
PATIENT'S DIAGNOSIS (To be completed by the Physician) Primary Diagnosis							
Secondary Diagnosis							
Age	Sex	Height	Weight	In your opir	nion, does thi	s person i	require skilled nursing care
Date of Last Tuberculosis Test		TB Results (Circle One)		Treatment Needed (If Yes, see next line)		If Yes, see next line)	
			None Inactive	Active	Yes	No	
Explain Type of Treatment Needed							
List Any Contagious Diseases							
List Any Allergies							
Patient Ambulates With (Circle One)							
Unassis	ted Cane	Quad Cane	Walker Wh	eelchair (Other (explai	n):	
Continued	On Next Pa	ge					

I. PHYSICAL HEALTH STATUS (Circle	One) Yes	GOOI No	FAIR	POOR Assistive Device
1. Auditory Impairment	105			Tabbasi ve Device
2. Visual Impairment				
3. Wears Dentures				
4. Special Diet				
5. Substance Abuse Problem				
6. Bowel Impairment or Incontinency				
7. Bladder Impairment or Incontinency				
8. Motor Impairment				
9. Requires Continuous Bed Care				
II. CAPACITY FOR SELF CARE (Circle	One) Yes	GOOI	FAIR	POOR Comments
Able To Care For All Personal Needs	1 es	NO		Comments
2. Can Administer & Store Own Medications				
3. Needs Constant Medical Supervision	,			
4. Currently Taking Prescribed Medications				
5. Bathes Self				
5. Dresses Self				
7. Feeds Self				
3. Cares For His/Her Own Toilet Needs				
Able To Leave Facility Unassisted				
10. Able To Ambulate Without Assistance				
11. Can Handle Stairs Without Assistance				
2. Able To Follow Instructions 2. Able To Follow Instructions 3. Depressed 4. Able To Communicate 5. Potential For Wandering 6. Requires Observation While 6. Sleeping (Night Bed Checks)				
Please List Over-The-Counter Medi Needed For The Following Condition Headache Constipation	nc•			To The Client/Resident, As
3. Diarrhea				
Indigestion				
5. Other (specify condition)				
				9
· 0				12.
Physician's Name				
Address				
Physician's Signature				Date:

The Pines Assisted Living Home

Physicians Routine Orders

Constipation: Milk of Magnesia	30 ml by mouth	Every day if no BM
GI Upset: Mylanta	30 ml by mouth	3x daily as needed
Diarrhea: Kaopectate	30 ml by mouth	3x daily as needed
Pain: Tylenol	650 mg. by mouth	If no allergy to Tylenol every 6 hours as needed
Fever: Tylenol	650 mg. by mouth	If no allergy to Tylenol every 6 hours as needed for temp over 100 degrees.
Resident Name:		
Allergies:		
Physician Printed Na	me:	
Physician Signature:		Date:

The Pines: 6103 E. Abineau Canyon

Flagstaff, AZ 86004 Phone 928-526-1876

The Pines Assisted Living Home

Physician's Consent for Administration of Medication

To Whom It May Concern:	
I authorize the certified caregivers from The Pines Ass	isted Living Home to
assist with self-administration and/or administration fo	r (patient name)
	on a daily basis.
I also authorize the certified caregiver and/or manager medications in a mediset on a weekly basis as needed.	to place the
Physician's Printed Name:	
Physician's Signature:	Date:

The Pines Assisted Living Home 6005 E. Abineau Canyon Dr. Flagstaff, AZ 86004

Phone: 928-526-1876

The Pines

Current Tuberculosis Test Results

Patient Name:			
Testing Location: _			
Date of Test:		Date Read:	
Test Results:	□ Negative	□ Positive	
I verify that the test	results for the al	bove named patient are true:	
Printed Name of M	edical Practition	er	
Signature:		Date:	