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 | | | |
| | | | EDICAL INFORMA information contain | | | | authorized representative) cal examination of: | | | |
| Patient Nar | me | | | | | | | | | |
| To (Name a | Γο (Name and Address of Licensing Agency) | | | | | | | | | |
| Signature of Resident/Potential Resident and/or His/Her Authorized Representatives | | | | | | | | | | |
| PATIENT'S DIAGNOSIS (To be completed by the Physician) | | | | | | | | | | |
| Primary Di | | | 2 13 (2 3 3 3 | <u></u> | <u> </u> | | | | | |
| 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) | | If Yes, see next line) | | | | |
| | | | None Inactive Active | | Yes No | | | | | |
| Explain Type of Treatment Needed | | | | | | | | | | |
| List Any Contagious Diseases | | | | | | | | | | |
| List Any A | llergies | | | | | | | | | |
| Patient Am | bulates With | (Circle One) | | | | | | | | |
| Unassis | ted Cane | Quad Cane | Walker Wh | eelchair (| Other (explai | n): | | | | |
| Continued | On Next Pa | ge | | | | | | | | |

| I. PHYSICAL HEALTH STATUS (Circ | cle One) Yes | GOOD No | FAIR | POOR Assistive Device |
|---|-----------------|------------|------|----------------------------|
| 1. Auditory Impairment | 105 | | | Tabbasire 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 (Circ | cle One) Yes | GOOD No | FAIR | POOR Comments |
| Able To Care For All Personal Needs | 1 es | NO | | Comments |
| 2. Can Administer & Store Own Medication | ons | | | |
| 3. Needs Constant Medical Supervision | J115 | | | |
| Needs Constant Medical Supervision 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 Me Needed For The Following Condit . Headache 2. Constipation | ione. | | | To The Client/Resident, As |
| Diarrhag | | | | |
| Indigestion | | | | |
| 5. Other (specify condition) | | | | |
| | · | | | 9 |
| | | | | |
| Physician's NameAddress | | | | |
| Physician's Signature | | | | |