PHYSICIAN'S REPORT FOR ASSISTED LIVING HOME

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

Our Facilities The Pines: (928) 526-1876 Eldercare Springs: (928) 526-7069 Pine Meadows Ranch: (928) 522-8622	**Main Office:** Phone: (928) 635-6750 Fax: (928) 635-6751 688 S. Garland Prairie Rd Williams, AZ 86046 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 Address	City	State	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 Name
To (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 Diagnosis
Secondary Diagnosis

Age	Sex	Height	Weight	In your opinion, does this person require skilled nursing care

Date of Last Tuberculosis Test	TB Results (Circle One)	Treatment Needed (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) Unassisted Cane Quad Cane Walker Wheelchair Other (explain):

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I. PHYSICAL HEALTH STATUS (Circle One) **GOOD** **FAIR** **POOR**

	Yes	No	Assistive Device
1. Auditory Impairment			
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) **GOOD** **FAIR** **POOR**

	Yes	No	Comments
1. Able To Care For All Personal Needs			
2. Can Administer & Store Own Medications			
3. Needs Constant Medical Supervision			
4. Currently Taking Prescribed Medications			
5. Bathes Self			
6. Dresses Self			
7. Feeds Self			
8. Cares For His/Her Own Toilet Needs			
9. Able To Leave Facility Unassisted			
10. Able To Ambulate Without Assistance			
11. Can Handle Stairs Without Assistance			

III. MENTAL HEALTH STATUS (Circle One) **GOOD** **FAIR** **POOR**

	No Problem	Occasional	Frequent	Comments
1. Confused				
2. Able To Follow Instructions				
3. Depressed				
4. Able To Communicate				
5. Potential For Wandering				
6. Requires Observation While Sleeping (Night Bed Checks)				

Please List Over-The-Counter Medication That Can Be Given To The Client/Resident, As Needed For The Following Conditions:

1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Other (specify condition)	

Please List Current Prescribed Medications That Are Being Taken By Client / Resident:

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Physician's Name _____ **Phone:** _____

Address _____

Physician's Signature _____ **Date:** _____

Eldercare Springs Assisted Living Home

Physician's Consent for Administration of Medication

To Whom It May Concern:

I authorize the certified caregivers from Eldercare Springs Assisted Living Home to assist with self-administration and/or administration for (patient name)

_____ on a daily basis.

I also authorize the certified caregiver and/or manager to place the medications in a mediset on a weekly basis as needed.

Physician's Printed Name: _____

Physician's Signature: _____ Date: _____

Eldercare Springs Assisted Living Home
6005 E. Abineau Canyon Dr.
Flagstaff, AZ 86004
Phone: 928-526-1876

Eldercare Springs 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 Name: _____

Physician Signature: _____ Date: _____

Eldercare Springs: 6103 E. Abineau Canyon
Flagstaff, AZ 86004
Phone 928-526-1876

Eldercare Springs

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 above named patient are true:

Printed Name of Medical Practitioner _____

Signature: _____ Date: _____