Assisted Living
Physician's Statement

The Physician's Report must be completed and signed by a physician, physician's assistant or advanced nurse practitioner. Attach additional information as needed.

Applicant Information

Residents First Name:____________________________________

Residents Last Name:____________________________________

Date of Birth:____________________________________

Primary Physician's Name:____________________________________

Medical History and Current Medical Problems

Primary Diagnosis: ____________________________________

Secondary Diagnosis____________________________________

Chronic Conditions (including behavioral health): ____________________________________

Medication

Applicant requires the following assistance with medication, (check all that apply):

[ ] No Assistance
[ ] Reminder to take
[ ] Reading Label
[ ] Opening Bottle
[ ] Observing the Self Administration of Medication
[ ] Directing or guiding the hand of the resident as the self-administer medication
[ ] Administration of Medication

If administration of medication is required describe the task:____________________________________

Residents Complete Current Medication Regimen

Medication	Dosage	Reason prescribed	Means of Administration and Level of Assistance

If Medication Regimen is not listed please attach

Current Therapy Regimen

Does the resident follow any therapy regimen that is necessary to maintain or increase their functioning, mobility, or independence – No Yes - Describe:____

____

____

Assistive Devices, Technology, Equipment or Special Diet Used

Hearing impairment? No Yes - Describe: ____

____

Vision impairment? No Yes - Describe: ____

____

Mobility/Ambulation impairments? No Yes - Describe: ______________________________________

____

____

Special Diet needed? No Yes - Describe: ____

____

Medical Equipment or devices used? No Yes – Describe: ______________________________________

____

____

Use of Restraints (Bedrails, self-releasing safety belts, lap-top trays, wedge cushions, concave mattress, other) No Yes - Describe: ____

____

____

Required Assistance with Activities of Daily Living

(Please indicate to what level of frequency the individual requires (independent, occasional, often, or always) and indicate the extent of the assistance (minimum, moderate, or maximum)).

Frequency/ Extent	Independent	Occasional	Often	Always	Minimum	Moderate	Maximum
Bathing/ Hygiene							
Dressing							
Grooming							
Toileting							
Eating							
Transferring/ Ambulating							

Safety

Allergies? No Yes - Describe: ____________________

Disoriented? No Yes - Describe: ____________________

Memory Problems? No Yes - Describe: ____________________

Drug or alcohol use? No Yes - Describe: ____________________

At risk of causing harm to self or others? No Yes - Describe: ____________________

Wound Care/Prevention? No Yes - Describe: ____________________

Hospice/DNR/Comfort One? No Yes - Describe: ____________________

Please describe any additional information of significance

Additional recommendations for Care

Primary Physicians Signature:____________________**Date:**__________