APPLICANT'S MEDICAL CERTIFICATE – NURSING HOME

Name of Applicant: ____ Date of Birth: _____ / ______/ _____

A. Diagnosis

Primary: 1. ______________________________ Secondary: 1. ______________________________

2. ______________________________

3. ______________________________

B. Treatments/Medications

Please list all current therapies *(including physical, occupational, speech, etc.)*:

____

____

Can you recommend a physical exercise program? *(What types of exercise is the Applicant not permitted to do?)*

____

____

Please list all medications you are currently prescribing for the Applicant *(Please include name, dosage, frequency, and reason for prescribing)*.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Is the Applicant taking any non-prescription medications? ______ Yes _______ No *(If yes, please list.)*

1. ____
2. ____
3. ____

C. General Information

1. How would you rate the Applicant's orientation to:

Person:	_________ Good	__________ Fair	__________Poor
Place:	_________ Good	__________ Fair	__________Poor
Time:	_________ Good	__________ Fair	__________Poor

2. Has the Applicant or any member of the immediate family been treated in a mental hospital or suffered mental illness at any time? ______ Yes ______ No

   Remarks: ____

3. What level of mental dexterity is observed? *(circle one)*

   A. Alert and cooperative C. Senile
   B. Forgetful D. Withdrawn

4. Is there evidence of mental impairment? ____Yes ____No

5. Is there evidence of aggressive behavior? ____Yes ____No
   Is there evidence of combative behavior? ____Yes ____No
   Is there evidence of disruptive behavior? ____Yes ____No
   Is there a risk of Applicant exiting the facility (elopement)? ____Yes ____No

The COMMUNITY at PARKVUE

A not-for-profit retirement and health care service community

C. General Information *(cont.)*

6. Is there evidence of use of:

Alcohol ________ Yes ________ No   Tobacco _______ Yes _______ No
Narcotics ________ Yes ________ No   Sedative _______ Yes _______ No
Remarks: ____
____

7. Is applicant able to perform the following for him/herself?

Dressing: ________ No __________ Yes, with assist __________ Yes, independently
Bathing: ________ No __________ Yes, with assist __________ Yes, independently
Ambulation: ________ No __________ Yes, with assist __________ Yes, independently

8. Is there a need for a special diet? ________ Yes ________ No If yes, specify diet order: ________________________
____

9. Any known food or drug allergies? ____
____

D. Past Medical History

Please check all applicable items and describe the condition in detail. Include dates, if relevant.

( ) Tuberculosis ____
( ) Chicken Pox ____
( ) Prostate ____
( ) Urinary retention ____
( ) Cancer ____
( ) Diabetes ____
( ) Epilepsy ____
( ) Hypertension ____
( ) Coronary Heart Disease/Vascular Disorders ____
( ) Pacemaker - Date Inserted ____________Functioning ______Non-funct. ______Type ______________________
Dates to be monitored ____
( ) Pulmonary Disease ____
( ) Arthritis ____
( ) Ophthalmic Disorder ____
( ) Otological Disorder ____
( ) Hernia ____
( ) Incontinence of Bowel and Bladder ____
( ) Bleeding Disorders ____
( ) CVA ____
( ) Allergies (pollens, dust, soap, topical ointments, etc.) ____
( ) Other ____

Surgical History *(dates)*: ____
____

Burns, Trauma and Fractures *(include dates)*: ____
____

Immunization History: Pneumovax Date ___________________ Flu Vaccine Date _________________
Chicken Pox Date ___________________ Hepatitis Date ___________________ Tetanus Date _____________________
Other ____ Date ________________________

Immunizations: ____ Date ________________________

Date of last booster shot: ____

D. Past Medical History *(cont.)*

Hospitalizations *(within the past two years)*:

Date:	Reason for Hospitalization:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

E. Physical Examination

Temp _________ Pulse ___________ Respiration __________ Height ____________ Weight ____________ Blood Pressure

Note any abnormalities in the areas below:

General:	____Development ____Nutrition ____Appearance
Skin:	____Jaundice ____Petechiae ____Nodules ____Rash
Scars:	____(description) ______________________
Ears:	____Discharge ____Canals ____Drums ____Hearing
Eyes:	____Conjunctive ____Light Reaction ____Glaucoma
	____Accommodation ____Discs ____Cataracts (___R ___L)
Nose:	____Mucous Membranes ____Obstruction ____Discharge ____Sinus Problems
Mouth:	____Teeth ____Mucous Membranes ____Tonsils ____Pharynx
Neck:	____Thyroid ____Mass ____Veins
Breasts:	____Mass ____Tenderness ____Scars ____Nipples ____Discharge
Heart:	____Rate ____Rhythm ____Pulse ____Abnormalities ____Thrills ____Enlargement
	____Sounds ____Murmurs ____Gallop ____Other ____Extraneous sounds
Lungs:	____Percussion ____Tactile ____Fremitus ____Breath Sounds ____Rales
	____Wheezes ____Tracheostomy
Abdomen:	____Liver ____Spleen ____Kidneys ____Mass ____Hernia ____Scars
	____Bowel Sounds
Rectum:	____Hemorrhoids ____Sphincter ____Prostate ____Mass ____Tenderness
Extremities:	____Cyanosis ____Edema ____Ulcers ____Weakness ____Tremor ____Deformities
Bones/Joints:	____Kyphosis ____Scoliosis ____Lordosis ____Joint Swelling
	____Joint Tenderness ____Joint Stiffness ____Osteoporosis
Pelvic Exam:	____Pap Smear ____Date, Results ______________________
Peripheral Vessels:	____Posterior Tibial ____Dorsalis Pedis ____Ischemia ____Varicosities
Reflexes:	____Biceps ____Triceps ____Abdominal ____Knee ____Ankle
	____Plantar Responses ____Romberg

Does Applicant have any known contagious diseases? ______________________

____

F. Tuberculosis Screening

Does the Applicant exhibit any of the following signs/symptoms:

____Anorexia	____Productive cough (2-3 weeks duration)
____Hemoptysis	____Fever
____Night Sweats	____Easy Fatigability

Explain: ______________________

Has the Applicant every been infected with M. Tuberculosis bacilli? ____Yes ____No
Explain: ______________________

Has the Applicant ever been diagnosed as having active Tuberculosis? ____Yes ____No
Explain: ______________________

F. Tuberculosis Screening *(cont.)*

Has the Applicant ever received treatment for a suspected/confirmed case of Tuberculosis? ___Yes ___No

PPD/Mantoux
Date given ________________________ by _________________
Date results read ____________________ by _________________
Results ____________________________________ mm in duration

PPD/Mantoux
Date given ________________________ by _________
Date results read ____________________ by _________
Results ___________________________ mm in duration

G. Current Restorative Potential *(circle letter indicating your assessment)*

1. What is the maximum level of ambulation possible?
   - A. Independent
   - B. Assistance
   - C. Non-ambulatory *(If yes, indicate reason)* ____

2. What is the maximum level of ability to feed self?
   - A. Independent
   - B. Assistance working toward independence
   - C. No rehabilitation potential
   - D. Mechanical aides would benefit
   - E. Mechanical aides currently in use

3. What is the maximum level of elimination possible?
   - A. Independent
   - B. Probably bladder training to independence
   - C. Probably bowel training to independence
   - D. Totally incontinent

H. Special Care

1. Does Applicant use an assistive device for walking? ____Yes ____No
   If yes, check what kind: ____cane ____walker ____brace ____crutches ____wheelchair ____Other

2. Does Applicant have adequate vision? _______ Yes ______ No
   Does Applicant wear glasses? _______ Yes ______ No
   Is Applicant Blind? ________ In one eye? _______ Both eyes?

3. Does Applicant have a hearing problem? ______ Yes _______No
   Does Applicant wear hearing aid(s)? ______ Yes _______No
   If Yes - is condition chronic or temporary?_____________________________ Severe or mild? ________________________

4. Does Applicant wear dentures? _______ Yes ________ No __________ Full __________ Partial

I. Recommendations

Please list any additional recommendations *(use reverse side if necessary)*: ____________________________________

____

____

J. Signature

I believe that this person requires Nursing Home placement. Level of Care: ________________________________

Name of Physician *(please print)*: ____

Address: ____

Phone Number: ________________________________ License Number: ______________________________

Date: ________________________________ Signature: ______________________________________

Are you following this Applicant to facility? ____Yes ____No If no, referral: