

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B. Forgetful D. Withdrawn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



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: _____