



1510 17TH STREET
DENVER, CO 80202
303-595-4464
FAX 303-595-9225
TDD 1-800-659-2656



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OUR MISSION: TO PROVIDE AND PROMOTE QUALITY AFFORDABLE HOUSING & CARING SUPPORTIVE SERVICES

MEDICAL HISTORY

Applicant Name: _____ Date: _____

Medical Release Authorization: _____
(Resident/legal representative signature)

Physician Name: _____ Phone: _____

Physician Address: _____

Dear Dr. _____,

The above named individual has hereby signed authorization for you to assist in the evaluation for placement in our assisted living residence. Please complete and return this form, releasing any pertinent documents that may be helpful in providing care at our residence.

Diagnosis: _____

Current medical problems: _____

Medical/Surgical history: _____

Dietary restrictions (therapeutic diets not available): _____

Can applicant monitor his/her own dietary restrictions? Yes ___ No ___

History of destructive, aggressive or violent behavior or mental illness: _____

Blood Press. _____ Pulse _____ Resp. _____ Temp _____ Height _____ Weight _____

Date of Immunizations: Flu _____ Pneumovax _____ Tetanus _____

Date of last PPD _____ Results: _____

Date of last chest XRay: _____ Results: _____

Does applicant presently suffer from any communicable disease? Yes ____ No ____

If yes, please describe: _____

Current Medications and Treatments:

Drug:	Dose:	Directions:
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRN Medications:

Allergies:

Does applicant have any of the following conditions? If so, please describe below:

Incontinence	Yes ____ No ____	Ambulating Problems	Yes ____ No ____
Sensory Deficits	Yes ____ No ____	Colostomy Care	Yes ____ No ____
Foley Care	Yes ____ No ____	Recent Falls	Yes ____ No ____
Oxygen	Yes ____ No ____	Flow rate:	_____

Assistive Devices: Yes ____ No ____

Other Concerns:

____ I authorize the ALR staff to possess and supervise the administration of medications for this applicant according to the prescribed directions included here. These medications have been reviewed and approved.

____ This resident may self-administer all medications

To the best of your knowledge, could this individual function in assisted living without the benefit of skilled services on a regular basis? Yes ____ No ____

Dr. _____ Signature _____ Date: _____

Please call if you have questions.

Sincerely, _____