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

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 (therapeuticdiets 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 X-ray: ______ Results: _______________________________________

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

If yes, please describe:____

Current Medications and Treatments:

Drug: Dose: Directions:

____

____

____

____

PRN Medications:

____

____

Which medications would you like to be notified of if refused?____

____

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, ____