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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, _____