



710 EAGLE AVENUE – PO BOX 1119  
 KREMMLING, CO 80459  
 970-724-3530  
 FAX 970-724-3813  
 TDD 1-800-659-2656

EMAIL [CLIFFVIEW@SENIORHOUSINGOPTIONS.ORG](mailto:CLIFFVIEW@SENIORHOUSINGOPTIONS.ORG)

[WWW.CLIFFVIEWASSISTEDLIVING.ORG](http://WWW.CLIFFVIEWASSISTEDLIVING.ORG)



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 (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 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, \_\_\_\_\_