

MEDICAL INFORMATION

Name: Date of Birth: Telephone:

Address:

Authorization for release of medical information:

I hereby authorize the release of medical information requested in this report to complete my application process for residence at Givens Highland Farms Retirement Community.

Signature: Date:

Physical health of applicant is: Good Fair Poor

Primary diagnosis:

Secondary diagnosis:

When was this applicant's most recent appointment with you?

Has this applicant been hospitalized in the last 12 months? Yes No

Diagnosis at hospitalization:

What are applicant's prescribed medications? (You may attach separate list if necessary.)

.....
.....
.....

Does this applicant have medication allergies? Y / N Name meds

Does this applicant have food allergies? Y / N Name foods

Mental health of applicant is: Good Fair..... Poor

Mental health diagnosis:

Does this applicant:	Yes	No	Comment
Have substance abuse problems?
Use alcohol?
Use tobacco?

Cognitive Status:	Yes	No	Comment
Does this applicant have compromised cognitive status?
Is applicant able to follow instructions?
Does applicant have a valid driver's license and operate a motor vehicle?
Does this applicant have social interaction with family and friends?
Is this applicant able to order, store and administer own medications?

If not able to be responsible for medications, what kind of assistance is needed? Weekly Dispenser..... Daily Dispenser.....
 Administration Overseen..... Comments

Risk for falls:

What is this applicant's history of falls?
 No falls over past three months More than one fall in past three months
 Injury sustained?.....
 Would you classify this person's risk for fall as: high moderate or low
 Have you recommended that the applicant use: cane walker wheelchair

Printed Name of Physician:

Signature of Physician:

Address:

Telephone: (.....).....-.....

Date: / /

Please return form to:
Amy Nasta, Marketing Director
(828) 669-2817