PHYSICIAN'S MEDICAL INFORMATION

(828) 357-3611 Office
(828) 669-2817 Fax

MEDICAL INFORMATION

Name ____

Date of Birth ______________________ Telephone ______________________

Address ____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

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

Patient Signature ______________________________ Date ______________

TO PHYSICIAN - PLEASE COMPLETE AND RETURN:

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? Y / N

Diagnosis at hospitalization ____

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

____

____

DOES THIS APPLICANT HAVE:

Medication allergies? ____ Yes ____ No Name meds ______________________________

Food allergies: ____ Yes ____ No Name foods ______________________________

Have substance abuse problems? ____ Yes ____ No

Use alcohol? ____ Yes ____ No

Use tobacco? ____ Yes ____ No

over

Mental health of applicant is Good _____ Fair _____ Poor ______

Mental Health diagnosis ____

____

Prescribing Doctor's if currently receiving Physical Therapy ____

Cognitive Status

Does applicant have compromised cognitive status? ____ Yes ____ No

Is applicant able to follow instructions? ____ Yes ____ No

Does applicant have a valid driver's license and operate a motor vehicle? ____ Yes ____ No

Does applicant have social interaction with family and friends? ____ Yes ____ No

Is applicant able to order, store and administer medications? ____ Yes ____ No

If not able to be responsible for medications, what kind of assistance is needed? ____ Yes ____ No

______ Weekly Dispenser ______ Daily Dispenser ______ Administrative Overseen

Comments ____

Risk for fall:

What is the applicant's history of falls? ____

Number of falls in the past 3 months ____

Injury sustained? ____

Would you classify this person's risk for fall as: high _____ moderate _____ low _____

Have you recommended that the applicant use: cane _____ walker _____ wheelchair _____

Printed Name of Physician ____

Signature of Physician ____

Address ____

Phone ______________________________ Date ______________________________

***Please return to Amy Nasta, Marketing Director (828) 669-2817 fax**