PHYSICIAN'S EVALUATION

________________________________, has recently applied for residency at our Youville Assisted Living Residence. Residents at Youville receive assistance with personal care, medication reminders, meals and housekeeping. Youville does not provide behavioral management, wander management or skilled care. As a part of the application, we require a completed Physician's Evaluation Form.

Thank you in advance for your cooperation. If any questions should arise, please feel free to contact the Wellness Director at (617) 491-1234 Fax (617) 491-8838

I, ________________________________, hereby authorize and direct my physician to complete this Physician's Evaluation as part of my application/assessment for residency at Youville Assisted Living, and if necessary, to speak with the Wellness Nurse at Youville.

Signature: _____________________________ Date: _____________________

PATIENT OVERVIEW

Patient name: ____ Gender: M___ F___ DOB: ________________

Home address: ____

Date of most recent physical examination: ____________ How long has this applicant been your patient? __________

Allergies: ____ Diet: ________________________

Height: ________ Weight: ________ Blood pressure: ______________ Pulse: _________ Respiration: ___________

Date of last vaccination: Influenza: ________ Pneumonia: _________ Tetanus: ___________

Diagnosis (es); ACTIVE medical problems:

____

____

____

Pertinent INACTIVE medical problems; medical history:

____

____

____

Medications (please include appropriate dose and time of day for each medication):

____

____

____

Medical care over past 12 months (*check one*): ___daily ___ weekly ___ monthly ___ times per year

Treatments/special needs: ____

____

In general, how would you rate the health of your patient? (check one):

____ excellent _____ very good ____ good ____ fair ____ poor

Any drug or alcohol addiction problems: ___ yes ___ no

Any dietary restrictions: ____

____

Does your patient smoke? ___ yes ___ no

Any communicable diseases: ___yes ___no If yes, please explain: ______________________

____

MENTAL STATUS

To your knowledge, has the applicant any history of:

Mental illness: ___yes ___ no If yes, please explain: ______________________

Abnormal behavior: ___yes ___no If yes, please explain: ______________________

Depression: ___yes ___no If yes, please explain: ______________________

Has the applicant expressed present or past suicide ideation? ___ yes ___ no

If yes, please provide current treatment: ______________________

Does the applicant wander? ____yes ___no

Is the applicant completely oriented to reality? ___yes ___no

Is the applicant cognitively capable of requesting assistance? ___yes ___no

Is a psychiatric consultation recommended? ___yes ___no

Is a geriatric evaluation recommended? ___yes ___no

FUNCTIONAL STATUS

Is applicant able to independently order, store, dispense and self-administer his/her medications? ___ yes ___ no

Is applicant able to take his/her medications with reminders and assistance opening containers? ___ yes ___ no

Is applicant capable of understanding emergency procedures? ___ yes ___ no

Is applicant oriented to time? ___ yes ___ no

Is applicant oriented to place? ___ yes ___ no

Is applicant oriented to person? ___ yes ___ no

Is applicant independent of 1:1 supervision? ___ yes ___ no

Can applicant participate in decisions regarding care? ___ yes ___ no

What, if any, assistive devices or mobility aids are required? ______________________

____

Additional comments: ____

____

Please Complete	Yes	No	List condition and other pertinent information
Heart disease			
Angina			
Hypertension			
Stroke			
Seizure			
Emphysema			
Neuromuscular			
Asthma			
Diabetes			
Insulin dependent			
Able to manage own insulin			
Kidney disease			
Incontinence			
Bowel			
Bladder			
Fractures			
Arthritis			
Skin condition			
Cancer			
Memory impairment			
Diagnosis/Explanation			
Mental health problem			
Vision			
Hearing			
Adaptive device			

Hospitalizations during the last five years (*Please list condition and outcome*)

Medications

Name	Dosage	Route	Freq.	Name	Dosage	Route	Freq.

Please check the appropriate status box for each of the following:

	Medication Monitoring
	complete self-management and self administration of all medication
	needs only supervision and some assistance to self-administer
	needs only supervision to self-administer
	needs administration by licensed personnel
	Ambulation
	fully independent
	needs supervision
	needs assistance

	Eating
	fully independent
	needs supervision
	needs assistance
	Bathing
	fully independent
	needs supervision
	needs assistance
	Toileting
	fully independent
	needs supervision
	needs assistance
	Dressing
	fully independent
	needs supervision
	needs assistance

	Transferring
	fully independent
	needs supervision
	needs assistance
	Grooming/Personal Hygiene
	fully independent
	needs supervision
	needs assistance
	Nutrition Management
	fully independent
	needs supervision
	needs assistance

Can the applicant go outside unattended? ___yes ___no

Is the applicant physically capable of requesting assistance? ___yes ___ no

Is the applicant able to participate in an exercise program? ___yes ___no

SOCIAL/EMOTIONAL STATUS

Is the applicant interested and able to engage in social and recreational activities? ___yes ___no

Is the applicant able to manage his/her emotions? ___yes ___no

Is the applicant able to manage his/her family relationships? ___yes ___no

Is the applicant able to maintain contact with friends, community, and social groups? ___yes ___no

PHYSICIAN'S RECOMMENDATIONS

Is applicant appropriate for assisted living: ___yes ___no

What restrictions? ____

____

Applicant not recommended for residency based on the following history and findings: ______________

____

____

Please include any additional comments you feel would be helpful to us in reviewing this application: ________

____

____

Physician's signature:______________________________Date:______________

Physician's name (please print):______________________________

Address:______________________________

Telephone:______________________ Fax:______________________