ST. MARTIN'S IN THE PINES

Assisted Living & Specialty Care Assisted Living

The following 3 page form must be completed in its entirety and signed by the attending physician. This form must be completed in full for all new admissions, annual exams and re-admissions from the hospital. Failure to complete in full may result in a delay of admission for new residents or discharge for current residents.

Please call 314-4138 if you have any questions regarding this form.

Fax to 314-4140 or 314-4148.

ASSISTED LIVING
CLINICAL HISTORY, PHYSICAL EXAMINATION & PLAN OF CARE

IMPORTANT NOTE: FOR NEW ADMISSIONS, THIS EXAMINATION MUST BE COMPLETED WITHIN 30 DAYS PRIOR TO ADMISSION

Resident's Name:	Date of Birth:	Sex:

(Required Here)
Primary Diagnosis :

Past Medical History:
Illness: (Check all that apply)

☐ Anemia ☐ Alzheimer's Ds / Dementia ☐ Arthritis ☐ Cerebrovascular Ds

☐ CHF ☐ COPD ☐ Diabetes ☐ Depression ☐ GERD ☐ Heart Ds

☐ Hypertension ☐ Parkinson's Ds ☐ Renal Ds

Other Illnesses:

Past Surgeries: (please list) ☐ None

Is resident free from contagious diseases, including TB? ☐ Yes ☐ No

TB Skin Test: (check one) ☐ Negative ☐ Positive Date given_____

(required for new admission only) Date read _____

(Resident cannot be admitted to St. Martin's without the results of TB skin test or clear chest x-ray - Must be within the past 30 days. If chest x-ray is completed, the results must be attached to this physical)

Are assistive devices required and if so, which?

Physical Exam:

Height	Weight	Temperature	Blood Pressure
Pulse	Respirations	General Appearance	HEENT
Lungs	Heart	Abdomen	Musculoskeletal

Skin: (including rash, breakdown, ulcers)

Neurologic:	

Mental Status: (check one) ☐ Alert ☐ Occasionally Confused ☐ Always Confused

Vision: (check one) ☐ Normal ☐ Impaired ☐ Other

Hearing: (check one) ☐ Normal ☐ Impaired ☐Hearing Aids

ASSISTED LIVING
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Have there ever been any signs of depression? ☐ Yes ☐ No
If yes, describe treatment and current condition:

Continence: (Check)
☐ Continent of Bowel ☐ Occasionally incontinent ☐ Often incontinent
☐ Continent of Bladder ☐ Occasionally incontinent ☐ Often incontinent

This individual requires the following personal care and services:

☐ Yes ☐ No Assistance with grooming (shaving, oral hygiene)
☐ Yes ☐ No Assistance with bathing
☐ Yes ☐ No Assistance with transferring to and from restroom
☐ Yes ☐ No Assistance with getting in and out of bed
☐ Yes ☐ No Assistance with dressing
☐ **Resident DOES have the ability to self-administer all medications**
☐ **Resident DOES NOT have the ability to self-administer all Medications. Therefore, the facility will administer all medications.**
☐ Yes ☐ No Resident is at risk for falls.
☐ Yes ☐ No Resident is at risk for elopements.
☐ Yes ☐ No Resident has had uncontrolled behaviors within the last 6 months.
☐ Yes ☐ No Resident has experienced weight loss within the last 6 months.
Other special needs: _____

Diet: (must be one of the following, no other diets are offered):
☐ Regular ☐ No added salt ☐ Low concentrated sweets
Date of most recent pneumococcal vaccine _____ ☐ unknown
Date of most recent influenza vaccine _____ ☐ unknown

Routine Standing Orders:

Yes	No	
_____	_____	PPD yearly
_____	_____	Flu vaccine yearly
_____	_____	May see podiatrist as needed

Resident's name:

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Allergies (Medications, Food, other)

Current Medications *including over the counter*

Medication	Dosage	Strength	Freq	# Refills	Diagnosis

Other Orders (Therapy, Home Health, Equipment):

Physician Name:	Physician Signature:	Date:

Physician's Telephone:		Physician's	

Clinical Review by Licensed Nurse:	Nurse Signature:	Date: