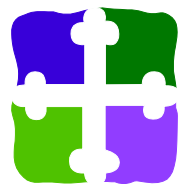


ASSISTED LIVING
CLINICAL HISTORY, PHYSICAL EXAMINATION & PLAN OF CARE



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:
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(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:

