Franke at Seaside
Lutheran Homes of South Carolina

PHYSICIAN'S MEDICAL STATEMENT AND REPORT

On_____, I performed a physical exam of _____ (must be within 30 days PRIOR to move in).

1. Current Diagnosis:
2. Physical Limitations:
3. Mental Health Limitations:
4. Treatment/Therapies: (Describe medical service or nursing care needed and attach a prescription).
5. Supportive Services Needed:
6. Allergies
7. Current Medications: (Current SIGNED prescriptions may be attached) Please include any PRN or OTC's that he/she may take as we are unable to assist or allow any medications without a written physician prescription.

MEDICATION	DOSE	ROUTE	TIME GIVEN

DIET INSTRUCTIONS: ___Regular ___No Added Salt ___No Conc. Sweets

STATUS OF THE FOLLOWING:

AMBULATING	BATHING	DRESSING	EATING
___Independent	___Independent	___Independent	___Independent
___Needs Supervision	___Needs Supervision	___Needs Supervision	___Needs Supervision
___ Needs Assist of 1	___ Needs Assist of 1	___ Needs Assist of 1	___ Needs Assist of 1

GROOMING	TOILETING	MOBILITY	MEDICATION
___Independent	___Independent	___Independent	___Self-Medicate
___Needs Supervision	___Needs Supervision	___Needs Supervision	___Needs Assistance
___ Needs Assist of 1	___ Needs Assist of 1	___ Needs Assist of 1	

Please read the following carefully and initial each of the following only if appropriate:

___ The individual's behavior does not pose a danger to self or others.

___ The individual is able to participate in supervised food preparation activities at will.

___The individual DOES NOT need 24 hour RN or LP supervision (in a skilled nursing home or hospital).

___ Based on the type of care the staff of Assisted Living may provide, the individual's needs can be met in an Assisted Living Community that is not a skilled nursing home.

___ It is my opinion that is individual requires a secured (locked) dementia care unit due to their cognitive limitations.

___The individual is free from signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact.

___ The individual is able to safely maintain and control security of common household cleaning chemicals and personal grooming supplies in own room/apartment.

___ The individual is able to safely maintain over-the-counter medication in own room/apartment and may self-medicate OTC's at own discretion (order to be renewed every 6 months).

Weight: _____ Temp: _____ B/P: _____ P: _____ R: _____

Hospital Preference: _____ Nursing Facility Preference: _____

Funeral Home Preference: _____

STATE REQUIRED FOR ADMISSION TO ASSISTED LIVING COMMUNITY:

Date 1st step PPD given:_____ Date 1st step PPD read:_____ Results of 1st step PPD:_____mm

2nd Step PPD to be done at Franke at Seaside

Date 2nd step PPD given:_____ Date 2nd step PPD read:_____ Results of 2nd step PPD:_____mm

X-ray results if resident known positive:_____ (Attach report as necessary).

I understand that assisted living residences are built in accordance with modern life safety and disability construction codes and fire protection requirements. In my opinion, this individual is capable of self-preservation with minimal human assistance (no more than 1 person) in an emergency involving the immediate evacuation of the facility.

Physician's Printed Name: _____

Physician's Signature_____

Address:_____

Phone: _____ Fax: _____ Date: _____

PLEASE RETURN TO:

Franke at Seaside, ATTN: Admissions
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