DOCTOR'S REPORT

For Resident of applicant for admission to Vibrant Aging Community Center

Notes to Physician

- The person specified below is a resident / client of or an applicant to Vibrant Aging Community Centre, an assisted living facility located in Winneba, Central Region.
- The facility provides primarily non-medical care, necessary to meet the needs of the individual residents / clients.
- The information that you complete on this person is required to assist in determining whether he/she is appropriate for admission to or continued care in our facility. We will also use this information to help us give them the best daily care within our power.

Resident information

Full Name	Date of Birth	National ID (type/#)

Address	Telephone

AUTHORIZED FOR RELEASE OF MEDICAL INFORMATION (To be completed by resident or resident's authorized representative) I hereby authorize the release of medical information contained in this report regarding the physical examination of:

Patient Name

To (Name and Address of Facility)

Signature of Resident/Potential Resident and/or Authorized Representative

PATIENT'S DIAGNOSIS (To be completed by the Physician)				
Primary Diagnosis				
Secondary Diagnosis				
Age	Sex	Height (m)	Weight (kg)	In your opinion, does this person require skilled nursing care

Date of Last Tuberculosis Test	TB Results (Circle One) None Inactive Active	Treatment Needed (If Yes, see next line) Yes No

Explain Type of Treatment Needed
List Any Contagious Diseases
List Any Allergies
Patient Ambulates With (please tick as appropriate) - Unassisted Cane - Quad Cane - Walker - Wheelchair - Other (explain):

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I. PHYSICAL HEALTH STATUS (Circle One)			GOOD FAIR POOR
Physical health condition	**Yes**	**No**	**Assistive Devise**
1. Auditory Impairment			
2. Visual Impairment			
3. Wears Dentures			
4. Special Diet			
5. Substance Abuse Problem			
6. Bowel Impairment or Incontinency			
7. Bladder Impairment or Incontinency			
8. Motor Impairment			
9. Requires Continuous Bed Care			
II. CAPACITY FOR SELF CARE (Circle One)			**GOOD FAIR POOR**
Area of self-care	Yes	No	Comments
1. Able to care for all personal needs			
2. Can administer & store own			
3. Needs constant medical supervision			
4. Currently taking prescribed			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Can handle stairs without assistance			

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III. MENTAL HEALTH STATUS (Circle One)			GOOD FAIR POOR	
	No problem	Occasional	Frequent	Comments
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				
5. Potential for wandering				
6. Requires observation while Sleeping (night bed				

Please List over-the-counter medication that can be given to the client/resident, as needed for the following conditions:	
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Other (specify)	
6. Other (specify)	

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Please List Current Prescribed Medications That Are Being Taken By Client / Resident:			
1.	_____	5. _____	9. _____
2.	_____	6. _____	10. _____
3.	_____	7. _____	11. _____
4.	_____	8. _____	12. _____

Doctor's Name: _____

Address _____

_____

_____

Doctor/Nurse Practitioner Signature _____ **Date:** _____