Eisenberg Assisted Living Residence

631 Salisbury Street
Worcester, MA 01609
Telephone # 508-757-0981 Fax # 508-757-7080

PHYSICIAN'S MEDICAL REPORT

Applicant (Mr. Ms. Mrs. Miss) ____________________DOB___________
Address of applicant____
____
Physician____
Physician's Address____
Physician's phone #____________________Fax #_______________

Medical Diagnosis: Primary__________________________________
Secondary__________________________________
____
Psychiatric__________________________________
History of psychosocial issues________________
Disruptive behaviors________________________
Any behaviors which may present a risk to the health and safety of the applicant or others____________
Psychiatrist (if applicable)____________________

Clinical Findings **Date**___________
Blood Pressure_________Pulse______Temperature________
Height_____________Weight___________
Urinalysis___________________________
Skin Condition____
Chest x-ray_________Date_________Mantoux_________Date_______
Is the applicant continent? Bowels: Yes___ No__Bladder: Yes___No____
Surgical History____
____
Recent Hospitalization
Reason________________________________Date_______________
Significant Laboratory Findings Date_______________
Allergies____
Menu Selection
_____Regular (Kosher) ____No added salt_____No concentrated Sweets____Low Fat
Any nutritional problems?___________Swallowing Problems?_________________

Equipment Used By Applicant

______Hearing Aid_______Dentures_______Glasses_______Prosthesis
______Cane_______Walker_______Wheel Chair_______Leg Brace
______Other ____

Does the applicant smoke: _____Yes_____No
Does the applicant use alcohol: _____Yes_____No_____How Often

Mental Status

_____Alert_____Oriented______Confused______Depressed_____Cooperative
_____Impaired Judgement_____Disruptive Sleep_____Abusive_____Assaultive
_____Memory Intact (if no, is loss:________short term __________long term)
_____Wanders

Functional Status

	Indep.	Needs Asst. (1 person)	Needs Asst. (2 people)	Totally Dependent
Stairs	_______	_______	_______	_______
Bathing	_______	_______	_______	_______
Dressing	_______	_______	_______	_______
Eating	_______	_______	_______	_______
Grooming	_______	_______	_______	_______
Housework	_______	_______	_______	_______
Manage Money	_______	_______	_______	_______
Meal Prep.	_______	_______	_______	_______
Phone Use	_______	_______	_______	_______
Transfers	_______	_______	_______	_______
Transportation	_______	_______	_______	_______
Walking	_______	_______	_______	_______
Wheeling	_______	_______	_______	_______

Vision:	Good________	Fair________	Poor________
Hearing:	Good________	Fair________	Poor________
Speech:	Good________	Fair________	Poor________

Does the applicant have a Legal Representative? Yes_____No_____
If yes, name of representative____
What is the representative's scope of authority?__________________________
Does the applicant have Advanced Directives: _____________Healthcare Proxy
______________________Comfort Care________________________DNR
Is the applicant appropriate for Assisted Living? ______Yes_____No
Comments:____
Physician's Signature________________________________Date_________

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Vision: Good_______Fair_______Poor_______
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____________________Comfort Care________________________DNR
Is the applicant appropriate for Assisted Living? ______Yes_____No
Comments:____
Physician's Signature______________________________Date__________

CURRENT MEDICATIONS

Name and Dose	Route of Adm.	Number Taken	How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Is the applicant able to self-administer and store own medications? Yes_______No______
Does the applicant require supervision of self administration? Yes_______No______
If yes, why ?____
Is the applicant able to manage and self-administer PRN medications? Yes_____No_____