

Assisted Living Physician's Statement

The Physician's Report must be completed and signed by a physician, physician's assistant or advanced nurse practitioner. Attach additional information as needed.

Applicant Information

Residents First Name: _____

Residents Last Name: _____

Date of Birth: _____

Primary Physician's Name: _____

Medical History and Current Medical Problems

Primary Diagnosis: _____

Secondary Diagnosis _____

Chronic Conditions (including behavioral health): _____

Medication

Applicant requires the following assistance with medication, (check all that apply):

- No Assistance
- Reminder to take
- Reading Label
- Opening Bottle
- Observing the Self Administration of Medication
- Directing or guiding the hand of the resident as the self-administer medication
- Administration of Medication

If administration of medication is required describe the task: _____

Residents Complete Current Medication Regimen

Medication	Dosage	Reason prescribed	Means of Administration and Level of Assistance

If Medication Regimen is not listed please attach

Current Therapy Regimen

Does the resident follow any therapy regimen that is necessary to maintain or increase their functioning, mobility, or independence – No Yes - Describe: _____

Assistive Devices, Technology, Equipment or Special Diet Used

Hearing impairment? No Yes - Describe: _____

Vision impairment? No Yes - Describe: _____

Mobility/Ambulation impairments? No Yes - Describe: _____

Special Diet needed? No Yes - Describe: _____

Medical Equipment or devices used? No Yes – Describe: _____

Use of Restraints (Bedrails, self-releasing safety belts, lap-top trays, wedge cushions, concave mattress, other) No Yes - Describe: _____

Required Assistance with Activities of Daily Living

Activity of Daily Living	Frequency of Assistance				Extent of Assistance		
	Independent	Occasional	Often	Always	Minimum	Moderate	Maximum
Bathing/Hygiene							
Dressing							
Grooming							
Toileting							
Eating							
Transferring/Ambulating							

Safety

Allergies? No Yes - Describe: _____

Disoriented? No Yes - Describe: _____

Memory Problems? No Yes - Describe: _____

Drug or alcohol use? No Yes - Describe: _____

At risk of causing harm to self or others? No Yes - Describe: _____

Wound Care/Prevention? No Yes - Describe: _____

Hospice/DNR/Comfort One? No Yes - Describe: _____

Please describe any additional information of significance

Additional recommendations for Care

Primary Physicians Signature: _____ Date: _____