Pre-Admission Health Examination

Resident Name: _____DOB_____/_____/_____

The Resident's Physician must supply the following information:

Physician: _____ID #_____

Address: _____

Phone number: _____ Fax _____

Date of last physical: _____

Ht_____ Wt_____ Eye color_____ Memory_____

Current status of resident summarized in brief:

_____

_____

_____

DIAGNOSIS LIST AND MEDICAL HISTORY
SYTEM REVIEW

(Pertinent Information Only for Assisted Living Care Professionals)

_____

_____

_____

_____

Surgical History

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

TB Skin Test Results: _____Date:_____

Allergies:

_____
_____
_____
_____

Physician's Orders:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List all medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The Ridges Of Lodi

Is this resident able to self-administer medications?

_____YES _____NO

Please check the necessary dietary needs:

No Concentrated Sweets _____

No Added Salt _____

General Diet _____

Ground Meat _____

SpecialtyDiet_____
_____
_____
_____

The Ridges
Of Lodi

Are there any activity restrictions recommended?

_____
_____
_____
_____

Does this resident require any therapy from an outside agency?

_____
_____
_____
_____

Are there any other special needs required by this resident for complete quality of life not mentioned elsewhere on this form?

_____
_____
_____
_____
_____
_____

I certify that this resident's medical condition and related needs are essentially as indicated above. I also certify that this resident is free of communicable disease.

Physician's Signature: _____

Date: _____

Physician's Phone in case of an emergency: _____