

APPLICANT'S MEDICAL CERTIFICATE - NURSING HOME

Name of Applicant: _____ Date of Birth: ____/____/____

A. Diagnosis

Primary: 1. _____ Secondary: 1. _____
2. _____
3. _____

B. Treatments/Medications

Please list all current therapies (*including physical, occupational, speech, etc.*):

Can you recommend a physical exercise program? (*What types of exercise is the Applicant not permitted to do?.*)

Please list all medications you are currently prescribing for the Applicant (*Please include name, dosage, frequency, and reason for prescribing*).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Is the Applicant taking any non-prescription medications? ____ Yes ____ No (*If yes, please list.*)

1. _____
2. _____
3. _____

C. General Information

1. How would you rate the Applicant's orientation to:

Person: _____ Good _____ Fair _____ Poor

Place: _____ Good _____ Fair _____ Poor

Time: _____ Good _____ Fair _____ Poor

2. Has the Applicant or any member of the immediate family been treated in a mental hospital or suffered mental illness at any time? ____ Yes ____ No

Remarks: _____

3. What level of mental dexterity is observed? (*circle one*)

A. Alert and cooperative C. Senile

B. Forgetful D. Withdrawn

4. Is there evidence of mental impairment? ____ Yes ____ No

5. Is there evidence of aggressive behavior? ____ Yes ____ No

Is there evidence of combative behavior? ____ Yes ____ No

Is there evidence of disruptive behavior? ____ Yes ____ No

Is there a risk of Applicant exiting the facility (elopement)? ____ Yes ____ No



C. General Information (Cont.)

6. Is there evidence of use of:

Alcohol: _____ Yes _____ No

Tobacco: _____ Yes _____ No

Narcotics: _____ Yes _____ No

Sedative: _____ Yes _____ No

Remarks: _____

7. Is the applicant able to perform the following for him/herself?

Dressing: _____ No _____ Yes, with assistance _____ Yes, independently

Bathing: _____ No _____ Yes, with assistance _____ Yes, independently

Ambulation: _____ No _____ Yes, with assistance _____ Yes, independently

8. Is there a need for a special diet? (*circle one*) _____ Yes _____ No If yes, specify diet order: _____

9. Any known food or drug allergies? _____

D. Past Medial History

Please check all applicable items and describe the condition in detail. Include dates, if relevant.

() Tuberculosis _____

() Chicken Pox _____

() Prostate _____

() Urinary Retention _____

() Cancer _____

() Diabetes _____

() Epilepsy _____

() Coronary Heart Disease/Vascular Disorders _____

() Pacemaker - Date Inserted _____ Functioning _____ Non-Funct. _____ Type _____

Dates to be monitored _____

() Pulmonary Disease _____

() Arthritis _____

() Ophthalmic Disorder _____

() Otological Disorder _____

() Hernia _____

() Incontinence of Bowel and Bladder _____

() Bleeding Disorders _____

() CVA _____

() Allergies (pollens, dust, soap, topical ointments, etc.) _____

() Other _____

Surgical History (*dates*): _____

Burns, Trauma, and Fractures (*include dates*): _____

Immunization History: Pneumovax Date _____ Flu Vaccine Date _____

Chicken Pox Date _____ Hepatitis Date _____ Tetanus Date _____

Other _____ Date _____

Immunizations: _____ Date _____

Day of last booster shot: _____

D. Past Medial History (cont.)

Hospitalizations (within the past two years):

Date:

Reason for Hospitalization:

E. Physical Examination

Temp: _____ Pulse: _____ Respiration: _____ Height: _____ Weight: _____ Blood Pressure: _____

Note any abnormalities in the areas below:

General: _____ Development _____ Nutrition _____ Appearance
Skin: _____ Jaundice _____ Petechiae _____ Nodules _____ Rash
Scars: _____ (description) _____
Ears: _____ Discharge _____ Canals _____ Drums _____ Hearing
Eyes: _____ Conjunctive _____ Light Reaction _____ Glaucoma
_____ Accommodation _____ Discs _____ Cataracts (_____ R _____ L)
Nose: _____ Mucous Membranes _____ Obstruction _____ Discharge _____ Sinus Problems
Mouth: _____ Teeth _____ Mucous Membranes _____ Tonsils _____ Pharynx
Neck: _____ Thyroid _____ Mass _____ Veins
Breasts: _____ Mass _____ Tenderness _____ Scars _____ Nipples _____ Discharge
Heart: _____ Rate _____ Rhythm _____ Pulse _____ Abnormalities _____ Thrills _____ Enlargement
_____ Sounds _____ Murmurs _____ Gallop _____ Other _____ Extraneous sounds
Lungs: _____ Percussion _____ Tactile _____ Fremitus _____ Breath Sounds _____ Rales
_____ Wheezes _____ Tracheostomy
Abdomen: _____ Liver _____ Spleen _____ Kidneys _____ Mass _____ Hernia _____ Scars
_____ Bowel Sounds
Rectum: _____ Hemorrhoids _____ Sphincter _____ Prostate _____ Mass _____ Tenderness
Extremities: _____ Cyanosis _____ Edema _____ Ulcers _____ Weakness _____ Tremor _____ Deformities
Bones/Joints: _____ Kyphosis _____ Scoliosis _____ Lordosis _____ Joint Swelling
_____ Joint Tenderness _____ Joint Stiffness _____ Osteoporosis
Pelvic Exam: _____ Pap Smear _____ Date, Results _____
Peripheral Vessels: _____ Posterior Tibial _____ Dorsalis Pedis _____ Ischemia _____ Varicosities
Reflexes: _____ Biceps _____ Triceps _____ Abdominal _____ Knee _____ Ankle
_____ Plantar Responses _____ Romberg

Does the applicant know of any contagious diseases? _____

F. Tuberculosis Screening

Does the Applicant exhibit any of the following signs/symptoms:

_____ Anorexia _____ Productive cough (2-3 weeks duration)
_____ Hemoptysis _____ Fever
_____ Night Sweats _____ Easy Fatigability

Explain: _____

Has the Applicant ever been infected with M. Tuberculosis bacilli? _____ Yes _____ No

Explain: _____

Has the Applicant ever been diagnosed as having active Tuberculosis? _____ Yes _____ No

Explain: _____

F. Tuberculosis Screening (cont.)

Has the Applicant ever received treatment for a suspected/confirmed case of Tuberculosis? Yes No

PPD/Matoux

Date given _____ by _____

Date results read _____ by _____

Results _____ mm in duration

PPD/Mantoux

Date given _____ by _____

Date results read _____ by _____

Results _____ mm in duration

G. Current Restorative Potential (circle letter indicating your assessment.)

1. What is the maximum level of ambulation possible?

A. Independent

B. Assistance

C. Non-ambulatory (If yes, indicate reason) _____

2. What is the maximum level of ability to feed self?

A. Independent

B. Assistance working toward independence

C. No rehabilitation potential

D. Mechanical aides would benefit

E. Mechanical aides currently in use

3. What is the maximum level of elimination possible?

A. Independent

B. Probably bladder training to independence

C. Probably bowel training to independence

D. Totally incontinent

H. Special Care

1. Does Applicant use an assistive devices for walking? Yes No

If yes, check what kind: cane walker brace crutches wheelchair Other

2. Does Applicant have adequate vision Yes No

Does Applicant wear glasses? Yes No

Is Applicant Blind? In one eye? Both eyes?

3. Does Applicant have a hearing problem? Yes No

Does Applicant wear hearing aid(s)? Yes No

If Yes - is condition chronic or temporary? _____ Sever or mild? _____

4. Does Applicant wear dentures? Yes No Full Partial

I. Recommendations

Please list any additional recommendations (use reverse side if necessary): _____

J. Signature

I believe that this person requires Nursing Home placement. Level of Care: _____

Name of Physician (please print): _____

Address: _____

Phone Number: _____ License Number: _____

Date: _____ Signature: _____

Are you following this Applicant to facility? Yes No If no, referral: _____
