

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B. Forgetful D. Withdrawn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 applicant able to perform the following for him/herself?

Dressing: _____ No _____ Yes, with assist _____ Yes, independently
Bathing: _____ No _____ Yes, with assist _____ Yes, independently
Ambulation: _____ No _____ Yes, with assist _____ Yes, independently

8. Is there a need for a special diet? _____ Yes _____ No If yes, specify diet order: _____

9. Any known food or drug allergies? _____

D. Past Medical 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 _____
- () Hypertension _____
- () 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 _____

Date of last booster shot: _____

D. Past Medical 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 Applicant have any known 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/Mantoux
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 device 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? _____ Severe 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: