Physician Form: Application for Admission

Community Village
An assisted living home for Seniors where God's love makes the difference.

Authorization to Copy Medical Records

Name of Doctor and/or Hospital _____

Address _____ City/St/Zip _____

Name of Patient _____

Current Address _____

Date of Birth _____ SSN# _____

I, the undersigned, hereby authorize any physician or nurse who attended me, or any hospital at which I have been confined and designated above, to furnish Community Village (3200 Hospital Road, PO Box 6518, Saginaw, MI 48608) with any and all information which may be requested regarding my past or present physical condition and treatment rendered, including but not limited to my consumption of alcohol or use of drugs, if applicable, and to allow them or any physician appointed by them to examine or copy any and all records or X-rays which you may have regarding my condition or treatment.

This authorization will be automatically revoked as soon as the purpose for which it has been given has been served or upon the occurrence of one or more of the following events, if any.

_____
(if none, write "none" on this line)

or on _____
(write "none" if no termination date is specified)

_____
Patient Signature Date Printed Name

This form is in compliance with Title 42 of the Code of Federal Regulations,
Part II (C.F.R. Revised October 1, 2012)

1706

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Code _____

Hospital of Choice _____

Physical Examination (to be completed by physician)

Name of Applicant _____ Date _____

Social Security Number _____ Date of Birth _____

Diagnoses _____

_____

1. Appearance _____

   Ambulation _____ Gait _____

2. Skin Problems: Bruises _____ Dressings _____ Cast _____

   Decubiti _____ Muscle Tone _____

3. Nutrition: Height _____ Weight _____

4. Head: Ears/Hearing Aid _____ Deafness _____ Right _____ Left _____

   Eyes: Glasses _____ Vision: Right _____ Left _____

   Glaucoma _____ Cataract _____

   Nose _____ Throat _____

   Speech: Normal _____ Impaired _____

   Mouth: Teeth _____ Dentures _____

   Edentulous _____ Tongue _____

5. Neck: Thyroid

6. Breasts: Right _____ Left _____

7. Lungs: Emphysema _____ Does applicant smoke? ____ How much? _____

8. Heart: Function = (circle) 1 2 3 4 B.P. _____ Pulse _____

   Murmurs □; Angina □; Heart Surgery □; Pacemaker □

9. Spine _____ Posture _____

10. Abdomen: Scars (surgical) □; Hernia □; Tumor □

11. Inguinal Area: Hernia _____

12. Genitalia _____ Bladder Function _____

13. Ano-Rectal: Hemorrhoids _____ Bowel Function _____

14. Extremities: Feet _____ Hands _____ Arthritis _____ Bones _____

    Joints _____ Mobility _____ Uses Cane □

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15. Neurological: Parkinson's □; Previous Stroke with Residual Paralysis □

16. Mental State: Oriented □; Confused □; Belligerent □

Withdrawn □; Overactive □; Noisy □; Forgetful □; Wanderer

17. Communication Ability: Can Speak □; Can Write □; Understands Speaking □

Understands writing and speaking □; Understands gestures □

18. Lab Reports: Chest X-Ray Report (within past three months) Date _____

19. Attending physician certifies that applicant is currently free from communicable disease _____

If not, please list _____

_____

20. List allergies: _____

_____

21. Current medications used (prescription and dosage): _____

_____

_____

22. Do you think applicant will adjust to congregate living? _____

23. We would appreciate any additional information presently or in the future that would be helpful for the applicant to adjust to congregate living. _____

_____

_____

24. Other comments: _____

_____

25. As the attending physician, I would make a house call to Community Village. Yes □; No □

I hereby certify that I have examined _____ and he/she is physically and mentally qualified for admission to Community Village.

_____

Physician Signature Date Printed Name

Address _____ City/St/Zip _____

Physician's Phone _____

Please mail this directly to: Director of Nursing, Community Village, PO Box 6518, Saginaw, MI 48608

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