



PHYSICIAN'S EVALUATION

_____, has recently applied for residency at Youville Place Assisted Living Residence. Residents at Youville Place receive assistance with personal care, medication reminders, meals and housekeeping. Youville Place does not provide behavioral management, wander management or skilled care. As a part of the application, we require a completed Physician's Evaluation Form.

Thank you in advance for your cooperation. If any questions should arise, please feel free to contact the Wellness Director at (781) 861-3535 Fax (781) 862-4289

I, _____, hereby authorize and direct my physician to complete this Physician's Evaluation as part of my application/assessment for residency at Youville Place, and if necessary to speak with the Wellness Nurse at Youville Place.

Signature: _____ Date: _____

PATIENT OVERVIEW

Patient name: _____ Gender: M ___ F ___ DOB: _____

Home address: _____

Date of most recent physical examination: _____ How long has this applicant been your patient? _____

Allergies: _____ Diet: _____

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____ Respiration: _____

Date of last vaccination: Influenza: _____ Pneumonia: _____ Tetanus: _____

Diagnosis (es); ACTIVE medical problems:

Pertinent INACTIVE medical problems; medical history:

Medications (please include appropriate dose and time of day for each medication):

Medical care over past 12 months (*check one*): daily weekly monthly times per year

Treatments/special needs: _____

In general, how would you rate the health of your patient? (*check one*):

excellent very good good fair poor

Any drug or alcohol addiction problems: yes no

Any dietary restrictions: _____

Does your patient smoke? yes no

Any communicable diseases: yes no If yes, please explain: _____

MENTAL STATUS

To your knowledge, has the applicant any history of:

Mental illness: yes no If yes, please explain: _____

Abnormal behavior: yes no If yes, please explain: _____

Depression: yes no If yes, please explain: _____

Has the applicant expressed present or past suicide ideation? yes no

If yes, please provide current treatment: _____

Does the applicant wander? yes no

Is the applicant completely oriented to reality? yes no

Is the applicant cognitively capable of requesting assistance? yes no

Is a psychiatric consultation recommended? yes no

Is a geriatric evaluation recommended? yes no

FUNCTIONAL STATUS

Is applicant able to independently order, store, dispense and self-administer his/her medications? yes no

Is applicant able to take his/her medications with reminders and assistance opening containers? yes no

Is applicant capable of understanding emergency procedures? yes no

Is applicant oriented to time? yes no

Is applicant oriented to place? yes no

Is applicant oriented to person? yes no

Is applicant independent of 1:1 supervision? yes no

Can applicant participate in decisions regarding care? yes no

What, if any, assistive devices or mobility aids are required? _____

Additional comments: _____

Please Complete	Yes	No	List condition and other pertinent information
Heart disease			
Angina			
Hypertension			
Stroke			
Seizure			
Emphysema			
Neuromuscular			
Asthma			
Diabetes			
Insulin dependent			
Able to manage own insulin			
Kidney disease			
Incontinence			
Bowel			
Bladder			
Fractures			
Arthritis			
Skin condition			
Cancer			
Memory impairment			
Diagnosis/Explanation			
Mental health problem			
Vision			
Hearing			
Adaptive device			

Hospitalizations during the last five years (*Please list condition and outcome*)

Medications

Name	Dosage	Route	Freq.	Name	Dosage	Route	Freq.

Please check the appropriate status box for each of the following:

Medication Monitoring	
<input type="checkbox"/>	complete self-management and self administration of all medication
<input type="checkbox"/>	needs only supervision and some assistance to self-administer
<input type="checkbox"/>	needs only supervision to self-administer
<input type="checkbox"/>	needs administration by licensed personnel
Ambulation	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance

Eating	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance
Bathing	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance
Toileting	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance
Dressing	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance

Transferring	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance
Grooming/Personal Hygiene	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance
Nutrition Management	
<input type="checkbox"/>	fully independent
<input type="checkbox"/>	needs supervision
<input type="checkbox"/>	needs assistance

Can the applicant go outside unattended? yes no

Is the applicant physically capable of requesting assistance? yes no

Is the applicant able to participate in an exercise program? yes no

SOCIAL/EMOTIONAL STATUS

Is the applicant interested and able to engage in social and recreational activities? yes no

Is the applicant able to manage his/her emotions? yes no

Is the applicant able to manage his/her family relationships? yes no

Is the applicant able to maintain contact with friends, community, and social groups? yes no

PHYSICIAN'S RECOMMENDATIONS

Is applicant appropriate for assisted living: yes no

What restrictions? _____

Applicant not recommended for residency based on the following history and findings: _____

Please include any additional comments you feel would be helpful to us in reviewing this application: _____

Physician's signature: _____ Date: _____

Physician's name (please print): _____

Address: _____

Telephone: _____ Fax: _____

