The Gardens at Calvary

7595 Moon Road **Phone: 706 - 653 - 2000**
Columbus, GA 31909 **FAX: 706 - 653 - 2045**

PHYSICIANS MEDICAL EVALUATION FOR ASSISTED LIVING

NAME OF ELDER		DOB	HEIGHT
PRESENT ADDRESS			WEIGHT
CITY	STATE	ZIP	TELEPHONE

REASON FOR EVALUATION
☐ Pre-Admission ☐ Annual ☐ Possible change in condition ☐ Other (Describe) ______________________________

1. Current Diagnosis

2. Physical Limitations

3. Mental Health Issues

4. Treatment/Therapies (Describe medical services or nursing care or treatment needed)

5. Supportive Services

6. Allergies

7. DIET INSTRUCTIONS: ☐ Regular ☐ No added table salt ☐ No concentrated sweets
☐ Other

8. STATUS OF THE FOLLOWING:

AMBULATING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ **Needs Total Help**
- ☐ **Bedridden**

BATHING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ **Needs Total Help**

DRESSING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ **Needs Total Help**

EATING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ **Needs Total Help**

ASSITIVE DEVICES
- ☐ Cane
- ☐ Walker
- ☐ Walker w/ Attachments
- ☐ Rollator Walker
- ☐ Wheel Chair
- ☐ Motorized Wheel Chair

GROOMING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ **Needs Total Help**

SKIN INTEGRITY
- ☐ No pressure sores
- ☐ Stage one
- ☐ Stage two
- ☐ Stage three
- ☐ Stage four

Location __________

TOILETING
- ☐ Independent
- ☐ Needs supervision
- ☐ Hygiene assistance
- ☐ Adult briefs
- ☐ **Catheter care assistance**
- ☐ **Ostomy**

TRANSFERRING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ **Needs Total Help**

RESTRAINTS
☐ Requires no restraints ☐ **Requires chemical restraints** ☐ **Requires physical restraints**
Type______________________________ Type______________________________

9. CIRCLE THE APPROPRIATE ANSWER IN EACH STATEMENT BELOW (a through e)

a. The individual HAS / HAS NOT received screening for TB and the individual HAS / DOES NOT HAVE signs and/or symptoms of infectious diseases which are likely to be transmitted to other Residents or staff. DATE: ______________ RESULTS ___________

b. The individual's behavior DOES / DOES NOT pose a danger to self or to others. If DOES, please explain. If medications are necessary to control behavior, please explain ______________________________

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(Continued from page one, item 9)

c. The individual DOES / DOES NOT require assistance from staff during the night. If assistance is required, please explain.

d. The individual DOES / DOES NOT require 24 hour nursing supervision.

e. The individual DOES / DOES NOT require placement in a specialized memory care unit (unit with controlled access/egress designed to serve residents who are at risk of engaging in unsafe wandering activities or other unsafe behaviors).

10. MEDICATIONS: List all medications including over the counter medications, herbal remedies, topical medications, vitamins, etc. Any PRN medications must include instructions, I.e. parameters for use.

MEDICATION	DOSAGE	INSTRUCTIONS FOR USE	ROUTE	NEEDS HELP WITH ADMINISTRATION
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

For additional listing of medications, see attached supplement to this form

If Resident receives Insulin: I certify the licensed nursing staff employed by The Gardens at Calvary to administer Insulin and monitor Blood Sugar per orders. I also approve the Resident Care support staff members to assist the Resident with the above procedures, provided they have been trained by one of the licensed nurses employed by the facility.

MEDICAL CERTIFICATION REQUIRED

Assisted Living facilities/personal care homes **ARE NOT permitted** under the law to provide medical, skilled nursing or psychiatric care. In your professional opinion, can this patient's needs be safely met in an assisted living facility or personal care home.

☐ **Yes** ☐ **No** COMMENTS:

Signature of Physician, PA or NP	Date
Printed Name of Physician, PA or NP	GEORGIA LICENSE #
Address	Phone:

City	State	Zip Code

PHYSICIANS MEDICAL EVALUATION FOR ASSISTED LIVING

SUPPLEMENTAL MEDICATION ORDER

MEDICATION	DOSAGE	INSTRUCTIONS FOR USE	ROUTE	NEEDS HELP WITH ADMINISTRATION
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
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				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

Signature of Physician, PA or NP	Date