

# IMMACULATE MARY HOME

2990 HOLME AVENUE  
PHILADELPHIA, PA 19136-1829  
(25)335-2100 \* FAX (215) 331-7454

**ONLY NECESSARY IF APPLICANT IS NOT CURRENTLY IN A HOSPITAL OR INSTITUTION**

## ATTENDING PHYSICIAN'S EVALUATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

For the purpose of determining my need for nursing facility services, I authorize the release of any medical information to Immaculate Mary Home.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Resident or Power of Attorney)

Attending Physician \_\_\_\_\_

### HISTORY:

Illnesses \_\_\_\_\_ Date \_\_\_\_\_  
Surgery \_\_\_\_\_ Date \_\_\_\_\_  
Accidents \_\_\_\_\_ Date \_\_\_\_\_  
Allergies \_\_\_\_\_ Date \_\_\_\_\_  
Drug Sensitivity \_\_\_\_\_

### HABITS:

Alcohol \_\_\_\_\_ Drugs \_\_\_\_\_ Smoking \_\_\_\_\_  
Family History \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Temperature \_\_\_\_\_ Pulse Rate \_\_\_\_\_ Cardiac Rhythm \_\_\_\_\_

### SYSTEMIC REVIEW OF APPLICANT:

Ears: Hearing \_\_\_\_\_ Tinnitus \_\_\_\_\_ Vertigo \_\_\_\_\_  
Eyes: Vision \_\_\_\_\_ Lacrimation \_\_\_\_\_ Pain \_\_\_\_\_ Glasses \_\_\_\_\_  
Nose: Discharge \_\_\_\_\_ Obstruction \_\_\_\_\_ Epistaxis \_\_\_\_\_  
Throat: Dysphagia \_\_\_\_\_

### RESPIRATORY SYSTEM:

Coughing \_\_\_\_\_ Expectoration \_\_\_\_\_ Wheezing \_\_\_\_\_ Dyspnea \_\_\_\_\_  
Cyanosis \_\_\_\_\_ Hemoptysis \_\_\_\_\_ Hoarseness \_\_\_\_\_

CVS: Chest Pain \_\_\_\_\_ Palpitations \_\_\_\_\_ Edema \_\_\_\_\_  
Syncope \_\_\_\_\_ Dypnea or Exertion \_\_\_\_\_

GI: Appetite \_\_\_\_\_ Nausea \_\_\_\_\_ Vomiting \_\_\_\_\_ Diarrhea \_\_\_\_\_  
Constipation \_\_\_\_\_ Bowel Incontinence \_\_\_\_\_ Abdominal Pain \_\_\_\_\_  
Jaundice \_\_\_\_\_ Flatulence \_\_\_\_\_ Hemorrhoids \_\_\_\_\_

DECUBITUS: Yes \_\_\_\_\_ No \_\_\_\_\_  
 Location: Extremities \_\_\_\_\_ Hip \_\_\_\_\_ Buttock \_\_\_\_\_ Other \_\_\_\_\_  
 If yes, check the following: Size \_\_\_\_\_ Depth \_\_\_\_\_ Drainage \_\_\_\_\_

GYN: Vaginal Discharge \_\_\_\_\_ Vaginal Bleeding \_\_\_\_\_ Menses \_\_\_\_\_ Menopause \_\_\_\_\_

NERVOUS SYSTEM: Headache \_\_\_\_\_ Weakness \_\_\_\_\_ Paralysis \_\_\_\_\_  
 Seizures \_\_\_\_\_ Syncope \_\_\_\_\_ Tremors \_\_\_\_\_

MUSCULO-SKELETAL: Pain \_\_\_\_\_ Weakness \_\_\_\_\_  
 Deformity \_\_\_\_\_ Limitation of Motion \_\_\_\_\_

SKIN: Itching \_\_\_\_\_ Dryness \_\_\_\_\_ Burning \_\_\_\_\_ Urticaria \_\_\_\_\_

FUNCTIONAL LEVEL (CIRCLE ONLY ONE LEVEL FOR EACH ITEM BELOW)

<u>ITEM</u>	<u>LEVEL 1</u>	<u>LEVEL 2</u>	<u>LEVEL 3</u>	<u>LEVEL 4</u>	<u>LEVEL 5</u>
Eating	Self	With Assist	Total Care	Tube feed	
Bathing	Self	With Assist	Total Care		
Dressing	Self	With Assist	Total Care		
Cont. of Urine	Continent	Occas. Incont.	Incontinent	Catheter	
Cont. of Bowel	Continent	Occas. Incont.	Incontinent	Colostomy	
Mental Status	Clear	Occas. Confused	Confused	Semi-Comatose	Comatose
Noisy	Never	Occasionally	Most of Time		
Agitation	Never	Occasionally	Most of Time		
Depression	Never	Occasionally	Most of Time		
Combative	Never	Occasionally	Most of Time		
Withdrawn	Never	Occasionally	Most of Time		
Wanders	Never	Occasionally	Most of Time		
Suicidal	Never	Occasionally	Most of Time		
Mobility	Ambulatory	WChair/Mobile	Cane/Walker	Chair bound	Bedfast
Sight	Not Impaired	Impaired	Blind		
Hearing	Not Impaired	Impaired	Deaf		
Speech	Not Impaired	Impaired	Language Barrier		

In the event of emergency, the resident can vacate the building:  
 Self \_\_\_\_\_ Under Supervision \_\_\_\_\_ No \_\_\_\_\_ Comment \_\_\_\_\_

Resident is capable of administering his/her own medications:  
 Self \_\_\_\_\_ Under Supervision \_\_\_\_\_ No \_\_\_\_\_ Comment \_\_\_\_\_

Test results and dates of most recent diagnostic studies, include chest x-ray, CBC, Urinalysis, and other studies substantiating the diagnosis:

---



---



---



---



---

Medical Complications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check Current Available Evaluations and summarize:

Rehabilitative:

P.T. \_\_\_\_\_ Comment: \_\_\_\_\_  
O.T. \_\_\_\_\_ Comment: \_\_\_\_\_  
Speech \_\_\_\_\_ Comment: \_\_\_\_\_  
Other \_\_\_\_\_ Comment: \_\_\_\_\_

DIAGNOSES:

Primary \_\_\_\_\_

Secondary \_\_\_\_\_

Tertiary \_\_\_\_\_

Does resident know his/her diagnosis? Yes \_\_\_\_\_ No \_\_\_\_\_

Prognosis – Check only one:

Stable \_\_\_\_\_ Improving \_\_\_\_\_ Deteriorating \_\_\_\_\_

Other (specify) \_\_\_\_\_

Rehabilitation Potential – Check only one:

Good \_\_\_\_\_ Limited \_\_\_\_\_ Poor \_\_\_\_\_

---

Professional and Technical Care Needs: Check each category that applies:

\_\_\_ Physical Therapy \_\_\_ Speech Therapy \_\_\_ Occupational Therapy

\_\_\_ Inhalation Therapy \_\_\_ Special Dressing \_\_\_ Irrigations

\_\_\_ Sp. Skin Care \_\_\_ Enteral Fluids \_\_\_ Suctioning

\_\_\_ Other (specify) \_\_\_\_\_

---

Immunizations Received:

Flu	Yes _____	No _____	Date Given _____
Pneumovax	Yes _____	No _____	Date Given _____
Tetanus	Yes _____	No _____	Date Given _____

PHYSICIAN ORDERS:

Medications \_\_\_\_\_

Treatments \_\_\_\_\_

Rehabilitative and Restorative Services \_\_\_\_\_

Therapies \_\_\_\_\_

Diet \_\_\_\_\_

Activities \_\_\_\_\_

Social Service \_\_\_\_\_

Special Procedures for Health and Safety to Meet Objectives \_\_\_\_\_

To your knowledge, does your patient have an Advanced Directive? Yes \_\_\_\_\_ No \_\_\_\_\_

Is your patient capable of making a decision? Yes \_\_\_\_\_ No \_\_\_\_\_

I recommend that the services and care to meet these needs can be provided at the level of care indicated. Check (X) only one:

\_\_\_\_ Daily care requires skill of Registered Nurse or Certified Therapist, i.e. Decubitus, daily P.T., Trach, N/G Tube, suctioning, cardiac monitoring, IM injections, unstable medical conditions, e.g. uncontrolled diabetes, uremia, etc.

\_\_\_\_ Daily care requires monitoring, assistance with activities of daily living, monitoring due to severe confusion, etc.

\_\_\_\_ Daily care requires total care with activities of daily living, feeding, incontinence care, ambulation reduction, redirection and communication, etc.

I certify that this patient's medical condition and related needs are essentially as indicated above and that care in a nursing facility is necessary.

Physician Name (Print Name) \_\_\_\_\_

Physician Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ MD \_\_\_ DO \_\_\_ DATE \_\_\_\_\_