IMMACULATE MARY CENTER
FOR REHABILITATION AND HEALTHCARE

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

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 _____ Hempotysis _____ 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)

ITEM	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
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 _____