WESTWIND MANOR

Assisted Living
25 Main Street
Franklin, New Jersey 07416
973.827.6575
westwindmanor.com

Physician's Immunization Administration Record

Patient's/Resident Applicant's Name ____
please print

Please check & give date where immunizations have been administered .....

2 Step PPD* _________ Last Date 2nd Step Administered _______________

Pneumovax _________ Last Date Administered ______________________

Tetanus _________ Last Date Administered ______________________

Ann Flu Vaccine _________ Last Date Administered ______________________

*If last PPD was administered over one year ago, a current 2 Step PPD administration is required before resident applicant can be admitted. If so......

Record of Current 2 Step PPD administration.....

1st PPD given date _____________ results ___________ results date___________

2nd PPD given date _____________ results ___________ results date___________

Physician's Signature ____

Printed Name ____________________________________Date______________

License No. & State ____

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PHYSICIAN'S MEDICAL CERTIFICATION

FOR ASSISTED LIVING

This is to certify that I have examined patient/ assisted living resident applicant....

____

Print Name

and found that........

(Check all that apply)

____Patient/Resident Applicant's level of care required IS appropriate for Assisted Living/Comprehensive Personal Care Home Resisdency.

____Patient/Resident Applicant is FREE of any communicable disease.

____Patient/Resident Applicant is NOT in need of specialized Long Term Care.

____Patient/Resident Applicant IS capable of managing self-administration and storage of his/her medications in his/her own room. This is subject to re-evaluation.

____ Patient/Resident Applicant is NOT capable of managing self-administration and storage of his/her medications in his/her own room. This is subject to re-evaluation.

Physician's Signature ____

Printed Name _________________________________Date_____________

License No. & State ____

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Annual Physical Examination

[to be completed by physician]

Name of patient/resident/resident applicant:

____

Date of Birth (DOB) ____________________Social Security No (SSN)____________________

Active Medical Condition(s) ____

____

Chronic Condition(s) ____

____

Medical History ____

____

Briefly describe hospitalization and/or surgeries within the past year ________________________

____

Any infectious or communicable diseases? Yes ___No___ If yes, please describe.

____

Need of any skilled services/care (i.e. VNA, PT, OT, etc.)? Yes ___No____ If yes, please describe.

____

Impressions of mental & emotional status ____

____

Allergies? Yes ____ No ____ If yes, please describe. __________________________________

____

General health status. ____

____

Annual Physical Examination (cont'd)

[to be completed by physician]

Patient/Resident/Resident Applicant's Name ____

	Normal	Impaired	Specify
Hearing			hearing aid (L/R) Deaf (L/R)
Speech			
Vision			glasses
Swallowing			dentures/upper/lower

Note: Our community offers Assisted Living Wellness checks, which include vital signs. Please list all medications including over-the-counter medications and dietary supplements.

Medication	Dose	Frequency	Treatment for/Diagnosis

1____

2____

3____

4____

5____

6____

7____

8____

9____

10____

Annual Physical Examination (cont'd)

[to be completed by physician]

Patient/Resident/Resident Applicant's Name ____

Diet (please circle after conferring with patient/resident/resident applicant)

Regular   CCD (consistent carbohydrate diet)   NAS (no added salt)

____

Vitals on Day of Examination   date: ______________________

BP ____________Pulse ____________ Height ____________Weight ___________

Currently in need health care requiring intervention (i.e. wound care, PT, OT, Speech, etc)?

Yes _____ No ______   if yes, please specify special services/care needed __________________

____

____

Date of Pneumovax _____________________ Date of Flu Vaccine ______________________

In your opinion, is this patient/resident/resident applicant appropriate to reside in an Assisted Living facility? Yes _____ No _____

Requires a secure, memory-impaired unit? Yes ____ No _____

If patient is also a resident applicant and is admitted, will you remain as his/her Primary Physician thereafter? Yes ______ No _______

Physicians' signature ____Date _______________

Print Name ____

Address ____

City/Town__________________________________State_________Zip_____________

Phone _______________________ Fax ____________________