REPORT OF RESIDENT PHYSICAL EXAMINATION

(Examination is to be completed by an independent physician within 30 days prior to the date of admission. Report is to be kept as part of the person's permanent record.)

NAME DATE OF PHYSICAL EXAMINATION:

ADDRESS

TELEPHONE

Height _____ Weight _____ BP _____

Significant Medical History:

_____

_____

_____

_____

General physical condition, including systems review as is medically indicated

_____

_____

_____

_____

_____

_____

Allergies (food, medicine, or other):

_____

_____

Is this person:

___ Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such resident may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate).

___ Nonambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).

PLEASE READ DEFINITIONS BEFORE CHECKING OFF.

Condition/Care Need	Yes	No	Comment
Ventilator Dependency			
Dermal Ulcers III and IV			Is stage III ulcer healing?
Intravenous therapy or Injections directly into vein			If intermittent therapy, please note and Indicate expected time period.
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission			
Psychotropic medications without appropriate diagnosis and treatment plans			
Gastric tubes			If yes, is person capable of independently feeding Himself and caring for the tube?
Presents imminent physical threat or danger to self or others			
Requires continuous licensed nursing care			

Name_____

Diagnosis or significant problems:

Recommendations for care:

Medications:

Diet:

☐ REGULAR

☐ DIABETIC

Therapy:

Signature:_____ **Date:**_____

_____

(Please print or type physician's name here)

Address (Street, City, State Zip Code)

_____ **Telephone:**_____

_____

REPORT OF TB SCREENING

Name: _____ Date of Birth: _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility/practice)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ A tuberculin skin test (PPD) was administered on _____ and results, read on _____, were as follows:
_____ mm _____ Negative _____ Positive.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)
Print Name/Title: _____ Phone: _____
Address: _____
_____
_____

TO: PHYSICIANS ATTENDING RESIDENTS OF SAINT FRANCIS HOME
RE: STANDARDS AND REGULATIONS FOR LICENSED ASSISTED LIVING FACILITIES

Medications (prescription, over-the-counter and dietary supplements):
22 VAC 40-71-400 C.
Physician orders, both written and oral, for administration of all prescription and over-the-counter medications and dietary supplements shall include the name of the resident, the date of the order, the name of the drug, route, dosage, strength, how often medication is to be given, **and identify the diagnosis, condition, or specific indications for administering each drug.**

As of 12/28/05 each medication prescribed for residents of Virginia licensed assisted living facilities must include the diagnosis, condition, or specific indications for administering each drug.

Please use the following form to provide this information for each medication you have prescribed for:

_____
PATIENT (Saint Francis Home Resident)

MEDICATION	DIAGNOSIS CONDITION, INDICATIONS FOR TAKING DRUG	SIGNIFICANT ADVERSE EFFECTS	DATE Prescribed	ADDITIONAL INFORMATION OR SPECIAL INSTRUCTIONS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Please attach written orders for each medication, and return to
Saint Francis Home | 65 W. Clopton Street | Richmond, VA 23225
Tel: 804 231-1043 Fax:804 231-1065

Physician's Signature _____ **Date:**_____