THE HOUSE OF THE GOOD SHEPHERD
798 WILLOW GROVE STREET
HACKETTSTOWN, NEW JERSEY 07840
Phone: 908-684-5900
FAX: 908-979-7030

Please give this form and the physical examination form to your family physician for completion.

Dear Doctor:

Your patient has given you the physical examination form for consideration for Admission to our Retirement Community. We cannot review this unless fully completed. Information required but not included on physical form includes the following:

A. Full name and address of patient.
B. Date the examination was done.
C. Five years synopsis of medical conditions.
D. Laboratory tests performed within the last three months.
   1. Chem 26 screening
   2. Complete blood count
   3. Urinalysis
   4. Electrocardiogram tracing
   5. We can only accept copies of actual reports.
E. Physician's signature
F. Printed name, address and telephone number

Ask your patient which area of this community she or he is applying for. The guidelines governing each are listed as follows:

Independent Living: Cottages and apartments in separate detached buildings and in new independent apartments. Resident must not need a walker or wheelchair, not be confused, able to hear a telephone or smoke alarm with a hearing aid. Vision is good and able to go into town for shopping needs. Does not need nursing care or medication supervision.

Assisted Living and Comprehensive Personal Care: Private rooms and apartments in our main building. Requires assistance in some activity of daily living and may require consistent physical and verbal cuing in addition to health maintenance monitoring.

Health Care Section: Needs nursing care, may be confused and need a wheelchair. Must not be belligerent to the point of being able to do harm to themself or another resident.

We cannot accept copies of office or hospital records except an adjunct to our physical examination form.

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PROSPECTIVE RESIDENT MEDICAL HISTORY

Name: ______________________________
Address: ______________________________

Telephone: ______________________________

Date of Birth: ______________________________
Social Security Number: ______________________________

Medicare Number: ______________ **Part A** ______ **Part B** ______
Other Health Insurance: ______________________________
____

Medicaid Number: ______________________________

Long Term Care Insurance: ______________________________
Type of Coverage: ______________________________

Physician	Address	Telephone

Diagnosis:
____
____
____

Hospitalizations within the past year:

Hospital	Dates	Reason

Prescription Medication:
____
____
____

Over the counter Medication taken regularly:
____
____

THIS FORM TO ACCOMPANY RESIDENT APPLICATION

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PROSPECTIVE RESIDENT MEDICAL HISTORY

Name: ____

Check all that apply:

Current Treatment(s) and Therapy(s):

___ Chemotherapy
___ Ostomy care
___ Tracheostomycare
___ Physical therapy
___ Speech therapy
___ Other – (Specify)____
___ Dialysis
___ Oxygen therapy
___ Transfusions
___ OT
___ Psychological therapy
___ IV Medication
___ Radiation
___ Ventilator or respirator
___ Respiratory therapy

Assistive Devices:

___ Glasses
___ Cane
___ Transfer aid (e.g., slide board, trapeze)
___ Confined to Bed
___ Contacts
___ Walker
___ Hoyer Lift
___ Hearing Aid
___ Wheelchair

Is there a history of:

___ Diabetes mellitus
___ Arthritis
___ Hypertension
___ Congestive heart failure
___ Arteriosclerotic heart disease
___ Cardiac dysrthythmias
___ Cerebrovascular accident (stroke)
___ Transient ischemic attack (TIA)
___ Hip fracture
___ Osteoporosis
___ Pathological bone fracture
___ Missing limb
___ Paraplegia
___ Quadriplegia
___ Parkinson's disease
___ Alzheimer's
___ Traumatic brain injury
___ Depression
___ Manic depression
___ Schizophrenia
___ Seizure disorder
___ Anxiety disorder
___ Asthma
___ Emphysema/COPd
___ Cataracts
___ Glaucoma
___ Macular degeneration
___ Cerebral palsy
___ Multiple sclerosis
___ Renal failure
___ Cancer
___ Allergies
___ Chronic pain
___ Incontinence of urine
___ Incontinence of bowel
___ Behavior problems
___ Wandering

Other:

____
____
____
____
____

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PROSPECTIVE RESIDENT MEDICAL HISTORY

Name: ____

Check all that apply:

ADL's	Independent	Some Assistance	Substantial Assistance	Total Dependence
Bathing				
Personal Hygiene				
Toileting				
Dressing				
Eating				
Ambulation				
Medication administration				

Other Pertinent Data and Notes: ______________________________

____
____
____
____
____
____
____

APPROVED FOR ADMISSION:

THE HOUSE OF THE GOOD SHEPHERD

____
Medical Director

____
Date

____
Executive Director

____
Date

SIGNED: ______________________
(Applicant's Physician)

Please Print:
Address: ______________________

City: ______________________

State: ______________________

Telephone: ______________________

Form A-9
Rev. 11/04

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MANTOUX TEST REPORT

Each applicant for admission must receive a Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exception should be applicants with documented negative Mantoux skin test results (0-9 mm. of induration) within the previous year, and patients with a documented positive Mantoux skin test result (10 or more mm. of induration) who have received appropriate medical treatment for tuberculosis.

1. If the Mantoux tuberculin skin test is negative, the test should be repeated one to three weeks later. If the second tuberculin skin test is negative, subsequent tests should be performed at the discretion of the facility.

2. If the first or second Mantoux tuberculin skin test is positive, a chest x-ray should be performed and, if necessary, followed by chemoprophylaxis or therapy.

NAME:________________________________ PHYSICIAN:____________________

DATE ADMINISTERED: ________________________ BY WHOM: ____________

DATE TEST READ (2 – 3 DAYS) __________________ BY WHOM: ____________

RESULTS MM/INDURATION

____

REPEAT TEST DATE (1 – 3 WEEKS) _______________ BY WHOM: ____________

DATE TEST READ: _____________________________ BY WHOM: ____________

RESULTS MM/INDURATION: ____

DATE OF CHEST X-RAY: ____

ALL TEST REPORTS ARE TO BE ATTACHED TO PHYSICAL EXAM UPON COMPLETION.

FORM A-28
REV. 4/96, 2/03