

Saint Mary Manor
701 Lansdale Avenue
Lansdale, PA 19446

MEDICAL EVALUATION

Name _____ Birth Date _____ Age _____ Sex _____

Chief Complaints &
Diagnosis: _____

Does resident know his/her diagnosis? _____ Yes _____ No

Is resident capable of understanding rights/health care decisions? If no, give medical reasons: _____ Yes _____ No

Medical History: _____

Recent Hospitalizations: _____ Date(s): _____

Drug Sensitivity: _____

Allergies: _____

Habits: Alcohol: _____ Drugs: _____ Smoking: _____

Family History: _____

History of Dementia: _____

PHYSICAL EXAMINATION

Check (X) if abnormal: HT _____ WT _____ BP _____ P _____ R _____

_____ Eyes	_____ Ears	_____ Heart	_____ Genitalia	_____ Neck
_____ Breasts	_____ Lungs	_____ Hernia	_____ Lymph System	_____ Ano-rectal
_____ Extremities	_____ Abdomen	_____ Nervous Sys.	_____ Mental Status	
_____ Muscle	_____ Peg Tube	_____ Colostomy	_____ Mouth	
_____ Skeletal	_____ Gastric Tube	_____ Throat	_____ Veins	
_____ Skin	_____ Nose	_____ Arteries	_____ Gynecological	

Describe Abnormalities: _____

Name: _____

Medical Conditions/Symptoms (Please grade as (1) mild (2) moderate (3) severe, any that apply to this patient).

Angina-rest Angina-exertion Orthopnea Dyspnea
 Dysphasia Contracture(s) Paralysis Pain
 Mental Disorder(s) - Specify: _____

Decubitus: No Yes Number _____ Location _____

If yes, Check (X) the following: _____ Size _____ Depth _____

Drainage: _____

Functional Level (Circle only one level for EACH ITEM BELOW):

ITEM	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Eating	Self	W/Assistance	Total Care	Tube Feed	
Bathing	Self	W/Assistance	Total Care		
Dressing	Self	W/Assistance	Total Care		
Cont.-Urine	Continent	Occas. Incont.	Incontinent	Catheter	
Cont.-Bowel	Continent	Occas. Incont.	Incontinent	Colostomy	
Mental Status	Clear	Occasionally	Confused	Semi-como.	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Withdrawn	Never	Occasionally	Most of Time		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		
Mobility	Ambulatory	Wheel Chair Mobile	Cane/Walker	Chair Bound	Bedfast
Sight	Not Impaired	Impaired	Blind		
Hearing	Not Impaired	Impaired	Deaf		
Speech	Not Impaired	Impaired	Aphasic		

NAME: _____

Patient is capable of administering his/her own medications:

_____ Self _____ No Comments: _____

Check (X) current available evaluations, rehab potential and needs:

Rehabilitative Services: _____ O.T. _____ P.T. _____ Speech _____ Other

Comments: _____

Immunizations Received:

Flu _____ Yes _____ No Date Given: _____

Pneumovax _____ Yes _____ No Date Given: _____

Tetanus _____ Yes _____ No Date Given: _____

Mantoux _____ Yes _____ No Date Given: _____

PHYSICIAN ORDERS:

Medications, Treatments, Diet, Therapies, Colostomy Care and Oxygen Therapy:

Copies of Lab Work Sent: _____ Yes _____ No

 _____ CXR _____ UA _____ CBC _____ EKG _____ SMA

NAME: _____

Physician Recommendation: To the best of my knowledge, the applicant's medical condition and related needs are essentially as indicated above.

I recommend that the service and care to meet these needs can be provided at the level of care indicated.

Check (X) only one:

_____ Medicare A: e.g. Decubitus, needing sterile dressings, daily PT, Trach, N/G Tube, G Tube, IM injections, unstable medical conditions following at least a 3 day hospital stay.

_____ Nursing Facility Services: must be fed or needs assistance with meals, w/c, g/c or bed bound. Moderate to severe confusion, needs complete care (bathing, dressing) totally incontinent, monitoring of personal care- e.g. 24 hour supervision and/or with ADL.

_____ Personal Care: e.g. requires assistance with medications, activities of daily living and/or financial matters.

_____ Independent: e.g. Independent in activities of daily living, medications and financial matters.

_____	_____	_____	MD _____
Physician (Printed Name)	Date	Physician Signature	DO _____

Physician Address

Telephone Number