

MEDICAL EVALUATION (PAGE 1 OF 4)

Check all that apply: AH EHP Initial RUG category change 12 month

	Name:			
	Facility name: TANGLEWOOD MANOR, INC.			
	Address: 560 Fairmount Ave. Jamestown, NY 14701			
	Sex:	Date of birth:	Weight:	B/P
Male <input type="checkbox"/>				
Female <input type="checkbox"/>				

Primary diagnosis:

Secondary diagnosis:

Significant medical history and current conditions:	Continance:	
	Bladder:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Bowel:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Diet:	
	House Diet/Liberalized Geriatric Diet <input type="checkbox"/>	

Needs assistance with self-administration of meds: Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies:
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List all current medications (prescription and OTC), including dosage, type, frequency, and method of administration, and note any special instruction (attach additional sheet if necessary):

MEDICATION	DOSAGE	TYPE	FREQUENCY	METHOD

 SIGNATURE OF PHYSICIAN (Required)

 DATE

MEDICAL EVALUATION (PAGE 3 OF 4)

Tanglewood Manor, Inc.
560 Fairmount Avenue
Jamestown, NY 14701

PPD Tuberculin Test:

Date given: _____
Name: _____
Address: _____
Date of birth: _____ Date of last menstrual period: _____
Past positive? _____ yes _____ no Date: _____
Lot #: _____
Contact of: _____
Other reason: _____
Location site: _____

SIGNATURE OF PHYSICIAN ADMINISTERING PPD TEST

Description of results:

No induration: _____
Width of indurated area (millimeter scale): _____ mm
Vesicle or necrosis present? _____ yes _____ no Date observed: _____

SIGNATURE OF PHYSICIAN

DATE

X-RAY: _____ yes _____ no Date: _____

Results of Chest X-ray: If No Active Tuberculosis please sign and date

SIGNATURE OF PHYSICIAN

DATE

EQUIPMENT:

_____, a resident at Tanglewood Manor, Inc., requires the following equipment for health reasons. He/She is able to use and maintain the equipment with staff assistance and supervision.

- _____ Oxygen Enricher _____ Liters per minute
- _____ Oxygen Concentrator _____ Liters per minute
- _____ Oxygen (Pressurized) _____ Liters per minute via _____
- _____ Finger Stick Blood Sugar (able to test himself/herself)
- _____ Lift Chair _____ Lift Bed without bedrails
- _____ Self Inject Insulin (pre-filled by facility nurse)
- _____ Nebulizer _____ CPAP

SIGNATURE OF PHYSICIAN

DATE

MEDICAL EVALUATION (PAGE 2 OF 4)

Tanglewood Manor, Inc.
560 Fairmount Ave.
Jamestown, N.Y. 14701

Name: _____

Is the Individual:

Free of communicable disease? Yes No If no, describe: _____

Able to transfer without assistance? Yes No If no, describe: _____

Ambulatory with assistance? Yes No If no, describe: _____

Describe activity restrictions / Assistance needed with ADLs (e.g. eating, transferring, toileting): _____

Describe current treatment plan (e.g., nursing, therapies, labs, etc.): _____

Is the Individual's condition stable? Yes No If no, describe: _____

Does the individual have a history, current condition or recent or current hospitalization for mental disability?

Yes No If no, describe: _____

Is a mental health examination recommended? Yes No

Date of today's examination: _____ Recommended frequency of medical exam: _____

I certify that I have describe the individual's medial condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared in an adult home, enriched housing program or an ALP.

Signature: _____
NURSE PRACTITIONER, PHYSICIAN'S OR SPECIALIST'S ASSISTANT

Date: _____

Signature: _____
PHYSICIAN (REQUIRED)

Date: _____

MEDICAL EVALUATION (PAGE 4 OF4)

Tanglewood Manor, Inc.
560 Fairmount Ave.
Jamestown, N.Y. 14701

Date: _____

Dear Dr. _____

We at Tanglewood Manor Adult Day Care and Adult Home are regulated by the New York State Department of Health; therefore, we are allowed to give only medications ordered by the physician.

We do carry some stock medications for PRN use:

- | | |
|---------------------|------------------|
| 1) Imodium AD | 4) Acetaminophen |
| 2) Milk of Magnesia | 5) Robitussin |
| 3) Maalox | |

We are required by the Department of Health to have a Physician's order to assist your patient _____

_____ with any of the above named medications.

Please check the box below if you agree that any or all of the above named medications would be allowed for Tanglewood Manor Adult Day Care and Adult Home to assist with for temporary relief of discomfort, headache, constipation, diarrhea, indigestion or cough. This form must be returned to Tanglewood Manor Adult Day Care and Adult Home for your patient's chart.

If prolonged use of or frequent use becomes apparent, we will notify you for the appropriate action.

Thank you,
Supervisor Personal Care

Please check if approval is given for the following:

- 1) Imodium A-D (Loperamide) [2mg cap – 1PO qid, PRN – Diarrhea]
- 2) Milk of Magnesia [2Tablespoonsful PO qd, PRN – Constipation]
- 3) Tylenol 325mg (Acetamin) [2tabs PO q4hrs, PRN – Pain of Temperature greater than 99°]
- 4) Maalox (Mintox) [1 Tablespoonful PO qid, PRN – Indigestion]
- 5) Robitussin (Guiatuss) 100mg./5ml [1 teaspoon PO q4hours, PRN – cough]

Signature: _____ Date: _____