New Cassel Retirement Center

Please Have Your Doctor Complete This Form

New Cassel is a licensed Assisted Living Facility

Medical Report

Regarding Patient (Name of Prospective Resident)_____

Dear Doctor:
The above-named individual has filed an application to live at New Cassel Retirement Center. **New Cassel is a licensed assisted living facility, providing a supportive environment**. New Cassel is not an alternative for those patients needing 24-hour nursing care.

Our Health & Wellness Center is staffed 24 hours a day, 7 days a week. Nurses are available for monitoring the health of our residents and will contact you if significant changes are noticed. Residents, with proper authorization from their physician, can have their medications dispensed by the Health & Wellness Center's licensed staff and have routine lab work completed and other therapies provided, coordinated with a third party.

New Cassel can also provide assistance with other personal needs including: three (3) meals per day, housekeeping, bathing, personal grooming, laundry, salon/barbering services, transportation for medical appointments, etc.

New Cassel requires a **Medical Report and History and Physical (90 days or less)** from the physician to determine if the individual is appropriate for assisted living.

Medical Release

I hereby authorize my physician to release the requested medical information to New Cassel Retirement Center.

_____ _____

Date Signature of Prospective Resident/Responsible Party

WHEN COMPLETED, PLEASE MAIL/FAX THIS REPORT TO:

Health & Wellness Center
New Cassel Retirement Center
900 North 90th Street Omaha, NE 68114
Fax: 402-393-3784

MEDICAL REPORT

Patient's Name_____ **DOB:**_____

Please check the appropriate responses:

1. MEDICAL STATUS

Patient Diagnosis(es)_____

_____

_____

Allergies? Yes____ No____

List_____

Past fractures/surgeries? Yes____ No____

List_____

Hospitalizations past 5 years? Yes____ No____

List_____

_____

At this time, are there any physical or mental health concerns that would put this person at risk when leaving the facility for an outing? Yes_____No_____

If yes, please explain: _____

_____

A. PHYSICAL ABILITIES

A. Ambulation

Ambulates without assistive device	Yes_____No_____
If no, ambulates with:	Cane____Walker____Wheelchair____
Transfers independently	Yes_____No_____
Has a history of falling	Yes_____No_____

B. Personal Care

Able to dress self	Yes_____No_____
Manages personal care	Yes_____No_____
Needs assistance with bathing	Yes_____No_____

C. Toileting

Bladder Control	Yes_____No_____
Bowel Control	Yes_____No_____
If no, patient self-manages	Yes_____No_____

D. Nutrition

Feeds self independently Yes_____No_____
Any difficulty swallowing? Yes_____No_____
Any difficulty chewing? Yes_____No_____
Diet type: Regular_____
No added sugar_____
No added salt_____
Supplements_____

E. Body Weight History

Current Visit: Date:_____Weight_____
Prior Visit: Date:_____Weight_____

3. SENSORY STATUS AND COMMUNICATION

Hearing Impaired Yes_____ No_____ Uses hearing aid_____
Visually Impaired Yes_____ No_____ Wears glasses_____
Speech Dysfunction Yes_____ No_____
Other Communication Problems Yes_____ No_____
Comments:_____

4. PSYCHOLOGICAL/ COGNITIVE STATUS

Oriented to person/place/time Yes_____ No_____
Needs some direction/reminders Yes_____ No_____
Wanders Yes_____ No_____
If yes, please explain:_____

_____

Able to seek help in emergency Yes_____ No_____
Current history of alcohol/drug dependency Yes_____ No_____

Current history of mental illness (Check any that apply):
Anxiety____ Depression____ Dementia____ Alzheimer's____
Abusive behavior____ Paranoia____ Other (please explain)_____

Course of treatment: Hospitalization____ Outpatient____ Medication____

Current Psychiatrist_____

5. MEDICATION MANAGEMENT

_____This patient is competent and physically capable of the act of taking or applying a dose of medication.
_____This patient should have medications dispensed and monitored by the New Cassel Wellness Center's licensed staff. Please attach medication orders to be filled.

Give Pneumovax .5cc, IM: Yes_____No_____ Date Pneumovax given:_____
May use generic medications: Yes_____No_____
Give annual flu vaccine? Yes_____No_____

Please list diagnosis for each medication:

Medications/Treatments	**For Condition/Diagnosis**

Other Orders:

PRN's

_____Tylenol gr. 10, po, every 4 hours, PRN pain/elevated temp

_____MOM 30cc, po, PRN once daily, constipation

_____Imodium 4 mg PO after 1st loose stool; 2 mg after each additional loose stool; MAX: 8 mg as needed for diarrhea

6. OTHER PHYSICIANS/SPECIALISTS TREATING PATIENT AT THIS TIME:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone #: _____

7. ANY OTHER INFORMATION REGARDING THIS PATIENT:

All medications quantity sufficient for one month with 12 refills unless otherwise noted. Medication aides may provide routine and PRN medications and all treatments and procedures within their scope of practice. This individual may be admitted to assisted living care. He or she does not require nursing home care.

Physician Signature_____ **Date:**_____

Dear Dr. _____ Date_____

Fax #_____

Your patient, _____, DOB: _____, may be interested in using the exercise equipment (treadmill, stationary bicycle, nu step, free weights, resistance bands, and/or weight machines, etc.) that we currently have available to our residents in the fitness center.

As a prerequisite to using the exercise equipment and fitness center, each resident is required to have his/her physician's approval. Therefore, it would be greatly appreciated if you could supply the following information so that they can begin their independent exercise program.

Please check:

A. _____ I know of no reason why s/he may not participate in an independent exercise program after an assessment of the individual's functional status and orientation to the equipment from a Physical Therapist has been completed.

B. _____ Physical Therapy is to evaluate and treat initiation of a home exercise program and a functional assessment of safety and compliance with equipment use.

C. _____ I strongly recommend that s/he NOT participate in using the exercise equipment.

D. Comments_____

_____ _____

Physician Signature Date

Thank you,

New Cassel Retirement Center