

Holy Trinity Eastern Orthodox Nursing & Rehabilitation Center
300 Barber Avenue
Worcester, MA 01606
(508) 852-1000

PHYSICIAN'S REPORT

All questions must be answered completely and recorded legibly

This report must be completed by a state licensed physician. The object of this report is to obtain an accurate statement of the present physical and emotional condition of the applicant as well as his/her medical history.

Applicant's Name: _____ Date of Birth: _____

Approximately how long has the applicant been under your care? _____

Is the applicant a smoker? If yes, please comment on smoking history _____

PATIENT'S MEDICAL HISTORY

Please list diagnoses: _____

Please list any hospitalizations (including psychiatric hospitalizations)

Hospital Name	Dates	Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S PRESENT CONDITION

Please list any conditions (including mental illness) that are currently being treated: _____

Applicant's Name _____

Please list all medications with directions:

Medication/Dosage

Medication/Dosage

Please list any known allergies (medication, food, others): _____

Please indicate applicant's current functioning level for
Activities of Daily Living:

BATHING Indep. Min Assist Mod Assist Tot. Assist

DRESSING Indep. Min Assist Mod Assist Tot. Assist

TOILETING Indep. Min Assist Mod Assist Tot. Assist

EATING Indep. Min Assist Mod Assist Tot. Assist

TRANSFER Indep. Min Assist Mod Assist Tot. Assist

Please indicate applicant's ability to ambulate:

Unable (Bedbound)

Cane

Independent

Quadcane

Contact Guard

Walker

Minimal Assist

Rolling Walker

Moderate Assist

Wheelchair

Special Shoes or Brace

Is the applicant capable of using stairs without assistance?

Yes No

Please indicate the number of falls the applicant has had during
the past year: _____

Have any injuries resulted from these falls? Yes No

If yes, please explain: _____

Applicant's Name: _____

Please explain the condition of the applicant's skin, including specific wound care needs _____

Please indicate the type of diet the applicant is currently on:

Regular NAS Diabetic Low Cal/Low Fat
 High Cal Supplements Other _____

Are there any diets textures modifications? Yes/No
If Yes, specify: Ground Puree

Thickened Liquids: Nectar Pudding Honey

Does the applicant have special feeding needs? (i.e., G-Tube).

Has the applicant lost a significant amount of weight while he/she has been under your care? Yes No
If Yes, please explain:

Applicant's Current Weight: _____ Height: _____

Applicant is: Continent Occasionally Incontinent

Incontinent of: Urine Bowels

Applicant has: Catheter Colostomy

Applicant's sight:

Normal Partially blind Legally blind
 Cataract Left Right
 Glaucoma Left Right

Applicant's hearing:

Normal Abnormal
 Hearing aid Left Right

Applicant's Name: _____

Applicant's mental status:

() Alert () Oriented to: () Person () Place () Time

() Other: _____

Please give results of the most recent lab work that has been completed including, urine analysis, blood work, E.K.G. and chest x-rays reports. _____

Is there any regular lab work required?

If so, please specify: _____

Please list any immunizations the applicant has received:

Immunization	Date
_____	_____
_____	_____
_____	_____

Please list the purpose for all visiting nurses services the applicant receives _____

Name of Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

NPI#: _____

UPIN#: _____

Physician's Signature: _____

Date: _____

The applicant will be considered for admission when this report is completed in full and returned to the admission department.

Thank you.

Please submit to: Angela Penny, COTA/L
Director of Admissions & Marketing