

Health History and Physical Data



The applicant named on this form is applying for residency at Carolina Meadows, a continuing care retirement community. This form is to be filled out by the applicant's health care provider. All information will be held in the strictest confidence. Each applicant must utilize a separate form. The applicant's signature authorizes the release of this medical information to Carolina Meadows. **Please note that Carolina Meadows does not admit smokers.**

TO BE FILLED OUT BY APPLICANT

(please print)

Applicant's name: _____
LAST FIRST INITIAL

STREET ADDRESS _____

CITY STATE ZIP PHONE () _____

DATE OF BIRTH AGE SEX: MALE FEMALE

SOCIAL SECURITY # MEDICARE # _____

APPLICANT'S SIGNATURE DATE _____

Waiting List Application Ready List Application **Please include the last six months of medical records on file if applying to Ready List.**

TO BE FILLED OUT BY HEALTH CARE PROVIDER

I Summary Statement of Applicant's Physical and Mental Capacities

Please check appropriate spaces and add comments as needed.

a. VISION: NO IMPAIRMENT GLAUCOMA MACULAR DEGENERATION
 CORRECTED WITH GLASSES CATARACTS SEVERE IMPAIRMENT

Comments: _____

b. HEARING: NO IMPAIRMENT HEARING AIDS SEVERE IMPAIRMENT DEAF

Comments: _____

c. MOBILITY: AMBULANT SEMI-AMBULANT CANE CRUTCHES
 WALKER WHEELCHAIR BEDFAST

Comments: _____

d. DRESSING: DRESSES SELF MINIMAL ASSISTANCE TOTAL ASSISTANCE

Comments: _____

e. EATING HABITS: FEEDS SELF MINIMAL ASSISTANCE TOTAL ASSISTANCE

Comments:

f. HYGIENE: BATHES SELF MINIMAL ASSISTANCE TOTAL ASSISTANCE

Comments:

g. CONTINENCE: URINARY: YES NO FECAL: YES NO USES COMMODORE BY SELF: YES NO

Comments:

h. MENTAL STATUS: ORIENTED, ALERT ANXIETY SUSPICIOUS PERSONALITY CHANGE
 DEPRESSION, SEVERE DISORIENTED HYPERACTIVE DEMENTIA
 CONFUSION WANDERS MEMORY LOSS COMBATIVE

Comments:

i. BEHAVIOR: NEEDS NO SUPERVISION MINIMAL SUPERVISION TOTAL SUPERVISION

Comments:

j. DOES PATIENT: SMOKE? YES NO DRINK ALCOHOL? YES NO # alcoholic beverages/week

Comments:

II Current Medications with Dosages (including vitamins, laxatives, or other OTC meds)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES:

III Current Diagnoses

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Comments:

XI Care Levels

Level of Care Chart (circle best)



Please check appropriate space below in consideration of your patient's needs.

INDEPENDENT LIVING

Able to care for self totally, moves about safely without assistance of any kind (except cane), fully continent or able to manage incontinence, mentally competent including able to take medications correctly, keep appointments and respond to emergencies.

ASSISTED LIVING

Able to meet activities of daily living needs with minimal assistance. Needs staff support, but not by licensed nursing staff. Continent or manages incontinence. Ambulatory by self or with devices.

NURSING CARE

Requires total physical care by staff, such as in activities of living, mobile only with help, requires maximum supervision by licensed nursing staff. Has physical disabilities which require rehabilitation or other skilled nursing procedures.

Comments on level of care:

(please print)

Health Care Provider's Name:

STREET

CITY

STATE

ZIP

()

PHONE

HEALTH CARE PROVIDER'S SIGNATURE

DATE

Please include the last six months of medical records on file if applying to Ready List.

Please return to:

Sales Director

Carolina Meadows

100 Carolina Meadows

Chapel Hill, NC 27517-8505

