

The Granville Assisted Living Center
1325 Vance Street
Lakewood, CO 80214
(303) 274-4400
Fax (303) 274-4100
www.TheGranvilleAssistedLiving.com

PHYSICIAN EVALUATION

Date: _____

Dear Dr. _____

Your patient has applied for residency at The Granville Assisted Living Center. This Center will provide limited, supplemental, non-medical service.

The staff at this center provide the following services:

1. Three meals a day plus snacks
2. Weekly housekeeping and laundry
3. Medication administration
4. Minimal dressing and bathing assistance

In order to reside here, a resident must be able to:

1. Perform activities of daily living with assistance if needed.
2. Accept necessary assistance from staff.
3. Maintain an odor free environment and person, independently.
4. Transfer independently.

In order to ensure that our residents are able to take advantage of this living environment, accurate health information is necessary. Please complete the attached questionnaire as accurately and completely as possible.

In the event of an emergency, we need to have an updated **ADVANCED DIRECTIVE** on file. If you have one on file for your patient, please provide that information as well.

Your patient's application will be considered when we have received your completed forms. Your prompt assistance is greatly appreciated. If you have any questions, please call me at 303-274-4400.

Sincerely,

Jaime Tafoya
Medication Coordinator

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Assisted Living Center
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PHYSICIAN EVALUATION

1. Patient's Name _____
DOB _____ Height _____ Weight _____
Blood Pressure _____
Nutritional Status _____
2. List Significant Diagnosis/Medical Problems. **MUST INCLUDE ICD-10 CODES**

3. Does patient suffer from any communicable diseases? Yes___ No___
If yes, explain: _____

4. Medications-Routine medications including prescription and over the counter drugs

Medication	Dose	Frequency	Reason

List Any Known Rx Allergies _____

List Any Known Food Allergies _____

Is this patient utilizing Oxygen? Yes_____No_____ If yes, please provide the order.

Please list any drugs that the patient may have on a **PRN basis**:

Medication	Dose	Frequency	Reason

5. Treatments/Therapies

6. Can this patient safely self-medicate? Yes____ No____

7. To your knowledge, how often has this patient fallen in the past year?

8. Does this patient appear to be oriented to person, place and time? Yes____ No____

9. To your knowledge, has this patient had any history of confusion? Yes____ No____

If yes, please explain _____

10. To your knowledge, has this patient had a history of wandering? Yes____ No ____

11. To your knowledge, has this patient had any history of mental illness or abnormal behavior? Yes____ No____

If yes, please explain _____

12. Does this patient have a history of any drug or alcohol abuse? Yes____ No____

If yes, in your opinion, is this a current problem? Yes____ No____

13. Is this patient in control of bladder? Yes____ No____

14. Is this patient in control of bowel? Yes____ No____

15. Does this patient require assistance with the following: (please check)

Bathing _____ Mobility _____ Eating _____ Dressing _____

Daytime Toileting _____ Nighttime Toileting _____

Other _____

16. Does this patient require the use of any device to assist with ambulation, such as a cane, walker, crutches or wheelchair? Yes____ No____

If yes, please indicate _____

17. What was the date this patient was last seen by you? _____

18. How long has this patient been under your care? _____

19. Does this patient have any restrictions in their ability to participate in the program's activities? Yes ____ No ____

If yes, please explain _____

20. Is this patient an appropriate applicant for an assisted living center? Yes___No___

Patient

Physician Signature

Date

Printed Name

Address

(_____)_____
Phone

(_____)_____
Fax

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Applicant's Consent to Release
Medical Information

I hereby authorize any physician, clinic or hospital to answer fully any request from The Granville Assisted Living Center for medical or psycho-social information concerning me as an applicant or while I am a Resident.

Printed Name

Signature

Date