

# Physician Packet

Dear Doctor:

I am moving into New Haven Assisted Living and Memory Care as a permanent resident. I am required to obtain the following information:

* 1. A signed physical exam completed within the last 30 days, which includes diagnosis, if applicable.
	2. A signed written order for my medication.
	3. A signed written order for any regular over-the-counter medications and instructions as to how they are to be taken, i.e., laxatives, pain relievers, cough syrup, etc.
	4. A signed written order for diet restrictions, and allergies.
	5. A signed written order for any special needs such as physical therapy, home health, etc.
	6. A signed written statement that I am free of communicable disease.

For your convenience, please complete the attached form regarding above request. By my signature on this letter, I give permission for your office to provide the appropriate information from my medical records. Upon completion please fax to (512) 400-0684 or return to requesting family member. Your help and immediate attention would be greatly appreciated.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESIDENT or POA SIGNATURE PRINTED RESIDENTS NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TODAYS DATE RESIDENTS DATE OF BIRTH

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_ Date of Physical\_\_\_\_\_\_\_\_\_\_

ALLERGIES:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Drug/Name** | **Dosage** | **Route/Frequency** |
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| **PRN Medications**If symptoms continue for 48 hoursMD will be notified  |  |  |
| **Acetaminophen 325 mg** | **2 tabs** | **PO Q 4 hrs. for pain or fever** |
| **Antacid**  | **30cc**  | **PO QID GI upset** |
| **MOM** | **30cc** | **PO QD for constipation** |
| **Imodium AD**  | **1 cap** | **PO Q 4 hours for loose stool** |
| **Triple Antibiotic ointment** |  | **According to product instructions** |

I feel this resident  **YES**  **NO** capable of safely administering and or managing his/her esidencyown medications.

I feel this resident is appropriate for Assisted Living. [ ] **YES**  [ ] **NO**

Has this resident had FLU Vaccine?  **YES**  **NO** **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this resident free of communicable disease(s) to include TB?  **YES NO**

THIS ORDER IS GOOD FOR (**CIRCLE ONE**) – 1 month- 3 months- 6 months - 1 year

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_