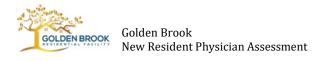


New Resident Physician Assessment



Dear Physician,

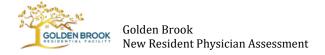
The patient bringing this information to you is applying for residency status at the Golden Brook Residential Facility. Golden Brook is a licensed, boned, and insured 10-bed dementia care home with 24/7 care located in Henderson, Nevada.

We would appreciate if you would complete the attached so we can consider your patient for our residence.

If you have any questions, please feel free to call us at 702-931-0055 and we will assist you with any questions.

Thank you so much!

The Golden Brook Team



New Resident Physician Assessment

| Patent Name: | t Name: Date of Birth: | | | f Birth: |
|---|------------------------|----------------|--------------|----------|
| Sex: M F | Date of | of Most Recent | Exam: | |
| Length of Time Under Care | : | | | |
| Primary Diagnosis: | | | | |
| Secondary Diagnosis: | | | | |
| Allergies: | | | | |
| Physical Health: | | | | |
| Height: Weight: | Normal Bloo | d Pressure: | Normal Temp: | |
| General Health: Good | Fair | | Poor | |
| Condition on a stable and pr | edictable cours | e: Yes | No | |
| Auditory Impairment: | None | Mild | Severe | |
| Visual Impairment: | None | Mild | Severe | |
| Special Diet: | Yes | No | Туре: | |
| Alcohol Problem: | None | Mild | Severe | |
| Respiratory Limitations: | Yes | No | Oxygen | Liters |
| Mental Health: | | | | |
| Alert & Oriented: | Person | Place | Time | |
| If no, please explain: | | | | |
| | | | | |
| | | | | |
| | | | | |
| Mental status score if compl | eted (MMSE): | | | _ |
| Able to follow orders: | Yes | No | Moderately | |
| Confused part of the time: Updated 8.27.21 | Yes | No | Moderately | |



| Go | olden Broo | k | |
|----|------------|-------------|------------|
| Ne | ew Residen | t Physician | Assessment |

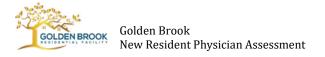
| Depressed: Y | /es | No | Moderately | |
|-----------------------------------|-----------|------------|---------------------|---|
| <u>Clinical Health:</u> | | | | |
| EENT: | | | | |
| | | | | |
| Lungs: | | | | |
| | | | | |
| Heart: | | | | |
| | | | | |
| Abdomen: | | | | |
| | | | | |
| Extremities: | | | | |
| | | | | |
| Skin: | | | | |
| | | | | |
| Mental/Neuro: | | | | |
| | | | | |
| Other assessment/Diagnosis: | | | | |
| | | | | |
| <u>Capacity for Self-Care:</u> | | | | |
| Assistive Devices: Cane V | Valker V | Vheelchair | _Hearing Aids Other | _ |
| Able to care for all personal new | eds: Yes_ | No | With Assistance | |
| Can administer own medication | ns: Yes_ | No | With Assistance | |
| Can transfer out of bed: | Yes_ | No | With Assistance | |
| Can walk independently: | Yes_ | No | With Assistance | |
| Ability to Bathe Self: | Yes_ | No | With Assistance | |

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Updated 8.27.21



| Ability to Dress Self: | Yes | No | With Assistance |
|----------------------------|-----|----|---------------------|
| Ability to Feed Self: | Yes | No | With Assistance |
| Ability to Toilet Self: | Yes | No | With Assistance |
| Bladder Control: | Yes | No | Occasional Problems |
| Bowel Control: | Yes | No | Occasional Problems |
| Physician Signature: | | | Date: |
| Print Physician Name Here: | | | |



STANDARD PLACEMENT DETERMINATION

Patient Name:

Place an "X" in the box next to the facility type that in your opinion most closely describes the care and services required by this Resident. The first five boxes listed below are for placement in a Residential Facility for Groups (NRS 449.017*). The last box is for placement in a skilled nursing facility (NRS 449.0039**).



A residential facility which provides care to persons with Alzheimer's disease or related dementia, including, senile dementia, organic brain syndrome or other cognitive impairment. These facilities are equipped with wander control systems and staffing requirements of at least 1 caregiver to each 6 residents.



A residential facility which provides care to persons with mental retardation or related disorders, including, birth trauma, anoxia, brain trauma or other genetic or developmental disorders. These facilities provide care and protective supervision in accordance with the needs of a person suffering from mental retardation.



A residential facility which provides care to persons with chronic illnesses or progressively debilitating diseases, including, acquired immunodeficiency syndrome and cancer. These facilities provide care and protective supervision in accordance with the needs of a person suffering from a chronic debilitating illness.

A residential facility which provides care to persons who are elderly or disabled or who require assistance or protective supervision because they suffer from infirmities or disabilities. These facilities provide care and protective supervision in accordance with the needs of a person suffering from old age or disabilities.

A residential facility which provides care to persons with mental illness, including, schizophrenia, bipolar disorder, psychosis and other related disorders. These facilities provide care and protective supervision in accordance with the needs of a person suffering from mental illness.

This resident requires placement in a facility capable of providing a higher level of care. Please see definitions below.

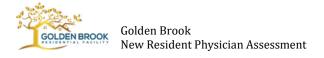
Physician Signature:

Date: _____

Print Physician Name Here:

*NRS 449.017 Residential facility for groups means an establishment that furnishes food, shelter, assistance and limited supervision to an aged, infirm, mentally retarded or handicapped person.

**NRS 449.0039 Facility for skilled nursing means an establishment which provides continuous skilled nursing and related care as prescribed by a physician to a patient in the facility who is not in an acute episode of illness and whose primary need is the availability of such care on a continuous basis.



CURRENT STAGE OF DEMENTIA

Patient Name:

Place an "X" in the box next to the stage of dementia that in your opinion most closely describes this Resident:



No Impairment. Someone at this stage will show no symptoms.

Early Decline. They will have problems with making plans and remembering recent events. They may have a hard time with traveling and handling money.



Mild Decline. They may not remember their phone number or their grandchildren's names. They may be confused about the time of day or day of the week. They will need assistance with some basic day-to-day functions, such as picking out clothes to wear.



Severe Decline. They will begin to forget the name of their spouse. They will need help going to the restroom and eating. You may also see changes in their personality and emotions.

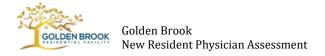


Very Severe Decline. They can no longer speak their thoughts. They can't walk and will spend most of their time in bed.

Physician Signature:

Date: _____

Print Physician Name Here:



PHYSICIAN VERIFICATION OF MEDICATIONS AND RECOMENDATION

Patient Name:

The purpose of this communication is to verify the medications that your patient is presently taking. Please list all current medications. Medications are hereby authorized to be given as soon as available.

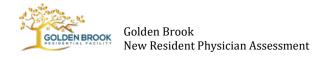
| MEDICATION | DOSE | ROUTE | FREQUENCY |
|------------|------|-------|-----------|
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I recommend that this person have medications retained and supervised/administered by Golden Brook Residential Facility.

Physician Signature:

Date:

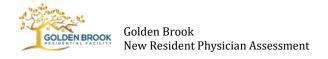
Print Physician Name Here:



TUBERCULOSIS SCREENING

| A TB test must be administered price | or to admission to Golden Brook. |
|--------------------------------------|----------------------------------|
|--------------------------------------|----------------------------------|

| Patient Name: | | | | |
|---|--------------|-------------------|--------------------------------|-----------------|
| TUBERCULIN SKIN 1 | <u>TEST:</u> | | | |
| <u>First step:</u> | | | | |
| Date given: | | Site: | | |
| Date read: | | Results: | Read by: | |
| Second step: | | | | |
| Date given: | | Site: | | |
| Date read: | | Results: | Read by: | |
| If tuberculin skin test res evaluation for active tube | | above named agree | s to submit to a chest radiogr | aph and medical |
| BLOOD TEST: | Date: | | Results: | |
| | | | | |
| CHEST X-RAY: | Date: | | Results: | |
| Assessment by physician | | - | | |
| | | | | |
| Physician Signature: | | | Date: | |
| Print Physician Name He | re: | | | |



COVID-19 SCREENING

| A COVID-19 test must be administered prior to admission to Golden Brook. |
|--|
|--|

| Patient Name: | | |
|--------------------------------------|-----------------|----------|
| COVID-19 TEST: | | |
| Date given: | | |
| Date read: | Results: | Read by: |
| Assessment by physician of signs and | symptoms: | |
| | | |
| | | |
| | | |
| COVID-19 VACCINATION: | | |
| Manufacturer of shot given: | | |
| First shot date given: | | |
| Second shot date given: | (if applicable) | |
| Booster shot date given: | (if applicable) | |
| Assessment by physician of signs and | symptoms: | |
| | | |
| | | |
| Physician Signature: | | Date: |
| Print Physician Name Here: | | |