
# 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: _____ Date of Birth: _____

Sex: M _____ F _____ Date of Most Recent Exam: _____

Length of Time Under Care: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Allergies: _____

**Physical Health:**

Height: _____ Weight: _____ Normal Blood Pressure: _____ Normal Temp: _____

General Health: Good _____ Fair _____ Poor _____

Condition on a stable and predictable course: Yes _____ No _____

Auditory Impairment: None _____ Mild _____ Severe _____

Visual Impairment: None _____ Mild _____ Severe _____

Special Diet: Yes _____ No _____ Type: _____

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 completed (MMSE): _____

Able to follow orders: Yes _____ No _____ Moderately _____

Confused part of the time: Yes _____ No _____ Moderately _____

Depressed: Yes _____ No _____ Moderately _____

**Clinical Health:**

EENT: _____

_____

Lungs: _____

_____

Heart: _____

_____

Abdomen: _____

_____

Extremities: _____

_____

Skin: _____

_____

Mental/Neuro: _____

_____

Other assessment/Diagnosis: _____

_____

**Capacity for Self-Care:**

Assistive Devices: Cane ___ Walker ___ Wheelchair ___ Hearing Aids ___ Other ___

Able to care for all personal needs: Yes ___ No ___ With Assistance ___

Can administer own medications: 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 ___

| | | | |
|---|---|---|---|
| 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 prior to admission to Golden Brook.

Patient Name: _____

**TUBERCULIN SKIN TEST:**

First step:

Date given: _____ Site: _____

Date read: _____ Results: _____ Read by: _____

Second step:

Date given: _____ Site: _____

Date read: _____ Results: _____ Read by: _____

If tuberculin skin test result is positive, above named agrees to submit to a chest radiograph and medical evaluation for active tuberculosis.

**BLOOD TEST:** Date: _____ Results: _____

Assessment by physician of signs and symptoms of tuberculosis:

_____

_____

_____

**CHEST X-RAY:** Date: _____ Results: _____

Assessment by physician of signs and symptoms of tuberculosis:

_____

_____

_____

Physician Signature: _____ Date: _____

Print Physician Name Here: _____

## 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: _____