



## PHYSICIAN HEALTH ASSESSMENT

To accommodate the needs of your patient at Riverglen House, the following information is required.  
Thank you in advance for your prompt assistance.

### PERTINENT BACKGROUND INFORMATION

PATIENT NAME \_\_\_\_\_ DATE OF ASSESMENT \_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_  
TELEPHONE \_\_\_\_\_

#### Vital Signs

WT. \_\_\_\_\_ HT. \_\_\_\_\_ T. \_\_\_\_\_ P. \_\_\_\_\_ R. \_\_\_\_\_ B/P \_\_\_\_/\_\_\_\_

#### Medical History - Please provide brief medical history

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#### Diagnoses

Primary \_\_\_\_\_ Secondary \_\_\_\_\_  
Other Diagnoses/Problems \_\_\_\_\_

#### Procedures – Please list surgical procedures & approximate dates

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#### Allergies

#### Medications – Please list current medications and/or attach a separate page

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#### Vaccinations – Please document dates of last:

Flu Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_ Pneumovax \_\_\_\_/\_\_\_\_/\_\_\_\_  
Tetanus Toxoid \_\_\_\_/\_\_\_\_/\_\_\_\_ Tuberculin Test \_\_\_\_/\_\_\_\_/\_\_\_\_ Result \_\_\_\_\_

#### Routine Diagnostic Testing – Please attach photocopy of most recent report

**Dietary Requirements** – Please identify all that apply

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|---|--|
| <input type="checkbox"/> Regular Diet                 | <input type="checkbox"/> Diabetic Diet                   |
| <input type="checkbox"/> No Added Salt (NAS)          | <input type="checkbox"/> Low Sodium                      |
| <input type="checkbox"/> No Concentrated Sweets (NCS) | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Vegetarian                   | _____  |
| <input type="checkbox"/> Low Fat                      |  |
| <input type="checkbox"/> Low Cholesterol              | May patient consume alcoholic beverages?                 |
| <input type="checkbox"/> Mechanical Soft              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pureed                       | Limitations on alcohol use: _____                        |

**Functional Capabilities/Limitations**

**I= Independent    A=Needs Assistance**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Ambulation            | <input type="checkbox"/> Light Housekeeping        | <input type="checkbox"/> Reading         | <input type="checkbox"/> Verbal Communication  |
| <input type="checkbox"/> Bathing               | <input type="checkbox"/> Medication Administration | <input type="checkbox"/> Toileting       | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> Following Directions  | <input type="checkbox"/> Medication Management     | <input type="checkbox"/> Transfers       |  |
| <input type="checkbox"/> Dressing/Grooming     | <input type="checkbox"/> Personal Laundry          | <input type="checkbox"/> Writing         |  |
| <input type="checkbox"/> Handling Finances     | <input type="checkbox"/> Preparing Light Meals     | <input type="checkbox"/> Using Telephone |  |
| <input type="checkbox"/> Other (specify) _____ |  |  |  |

Appliances used (if applicable) \_\_\_\_\_

- |                           |              |               |            |                 |            |
|---------------------------|--------------|---------------|------------|-----------------|------------|
| <b><u>Orientation</u></b> | Person _____ | <b>Memory</b> | Good _____ | <b>Judgment</b> | Good _____ |
|                           | Place _____  |               | Fair _____ |                 | Fair _____ |
|                           | Time _____   |               | Poor _____ |                 | Poor _____ |

Explain need for supervision and/or assistance \_\_\_\_\_

**Communicable Diseases**    None \_\_\_\_\_

If known, please specify \_\_\_\_\_

**DNR Status**    Attempt Resuscitation?     Yes     No

**Additional Comments**

Completed by \_\_\_\_\_ Date \_\_\_\_\_  
(Signature)

Please mail or fax completed form to: Executive Director (or)  
Resident Care Supervisor  
Riverglen House  
55 Riverglen Lane  
Littleton, NH 03561

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Tel: 603-444-8880  
Toll Free: 800-545-5812