

**RIVERGLEN HOUSE
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 ASSESSMENT ____/____/____
DATE OF BIRTH ____/____/____
PHYSICIAN _____ ADDRESS _____
TELEPHONE _____

Vital Signs

WT. _____ HT. _____ T. _____ P. _____ R. _____ B/P ____/____

Medical History – Please provide brief medical history

Diagnoses

Primary _____ Secondary _____
Other Diagnoses/Problems _____

Procedures – Please list surgical procedures & approximate dates

Allergies _____

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

Vaccinations – Please document dates of last:

Flu Vaccine ____/____/____ Pneumovax ____/____/____
Tetanus Toxoid ____/____/____ Tuberculin Test ____/____/____ Result _____

Routine Diagnostic Testing – Please attach photocopy of most recent report

Continued on Reverse

Dietary Requirements – Please identify all that apply

- | | |
|---|---|
| <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 | |
| <input type="checkbox"/> Mechanical Soft | May patient consume alcoholic beverages? Yes___ 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) _____

- | | | | | | |
|--------------------|--------------|--------|------------|----------|------------|
| <u>Orientation</u> | Person _____ | Memory | Good _____ | Judgment | 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: Jason Purdy, Executive Director
Fax Number: 603-453-8519 Riverglen House Tel: 603-444-8880
55 Riverglen Lane
Littleton, NH 03561 Toll Free: 800-545-5812