



HERITAGE RELEASE FOR MEDICAL INFORMATION



FAMILY COMPLETES THIS SECTION

THE FORM BELOW MUST BE COMPLETED BY THE PHYSICIAN BEFORE MOVE IN OCCURS

I, _____, hereby authorize my physician _____ to completely and fully answer all of the questions under Physician's Statement as part of my application for residence at Heritage at Framingham Assisted Living Community, 747 Water Street, Framingham, MA 01701.

Applicant / Representative's Signature

Date

Applicant Name: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

PHYSICIAN'S STATEMENT

PHYSICIAN'S OFFICE---PLEASE COMPLETE ASAP & FAX TO: 508.788.6601

Your patient has applied for residency at Heritage at Framingham Assisted Living. Residents receive a full package of services: 3 meals daily, housekeeping weekly, linen service, daily personal care service; i.e., assistance with bathing, grooming, and dressing, an emergency response system and care management as needed. **STATE REGULATIONS REQUIRE THIS FORM BEFORE APPLICANT MOVES IN.**

Thank you for your assistance.

Please indicate primary diagnosis: _____

Significant past medical history: _____

Present health status: _____

Present mental status (for example, confusion, long and short term memory, depression, etc.):

Is applicant oriented to: Time: _____ Place: _____ Person: _____

Please describe any behavioral concerns which might help us in our care planning: _____

Current medications / dosages: _____

List any drug reactions: _____

List any allergies: _____



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PHYSICIAN'S STATEMENT-Continued

Is applicant able to follow your prescribed medical regime? Yes No

TB Test: Y N Date: _____ Results: _____

Please describe any sensory impairments: Vision: _____ Hearing: _____

Blood pressure reading: _____

Has applicant suffered from any illness during the past five years which would impair her/his physical or mental health?

Hospitalization(s) during the last five years? Y N Reason(s): _____

Is applicant on a special diet? N Y If yes, please explain dietary restrictions & how we might comply:

Please indicate applicant's need for assistance with activities of daily living: _____

Will resident need any of the following appliances or durable medical equipment?

Walker: Y N Cane: Y N Wheelchair: Y N Other equipment: _____

Please identify any other special needs the resident may require, and how they might be accommodated:

Your answers to the following questions will help our Resident Care Coordinator plan for your patient once he/she has moved into our community. Has the applicant had any of the following diseases or disorders? (Please answer yes or no). If yes, please provide any additional information which will aid in our care planning for this resident.

Heart Disease: _____

Infarcts: _____

Angina: _____

Stroke: _____

Emphysema: _____

Paralysis: _____

Diabetes: _____

Aphasia: _____

Cancer: _____

Fractured Hip(s): _____

Urinary Problems: _____

Incontinence: _____

Hernias: _____

Arthritis: _____

Skin Conditions: _____

Epilepsy: _____

Hemorrhages: _____

Comments: _____

Primary Physician's Signature: _____

Physician's Name Printed: _____

City: _____ State: _____ Zip: _____ Phone: _____