



# MEDICAL INFORMATION FOR HERITAGE



**FAMILY: GIVE TO PHYSICIAN AFTER COMPLETING THIS RELEASE SECTION:**

I, \_\_\_\_\_, hereby authorize my physician \_\_\_\_\_ to completely  
(Family Representative) (Print Physician Name)  
and fully answer all questions under the 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 (Print): \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

## PHYSICIAN'S STATEMENT

State Regulations Require for All Assisted Living Applicants

**FAX COMPLETED FORM TO: 508.788.6601**

Complete this form relative to Assisted Living where residents receive:

3 daily meals, housekeeping, linen service an emergency system, and assistance with bathing, grooming, and dressing.

Please indicate **primary** diagnosis: \_\_\_\_\_

**Additional** diagnoses: \_\_\_\_\_

Significant **past** medical history: \_\_\_\_\_

Present **health** status: \_\_\_\_\_

Present **mental** status (e.g., confusion, long / short term memory, depression, etc.) \_\_\_\_\_

Is applicant oriented to **Time:** Yes  No  **Place:** Yes  No  **Person:** Yes  No

Please describe any **behavioral** concerns which might help in our care planning: \_\_\_\_\_

Current **medications**

/dosages: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**PHYSICIAN'S STATEMENT-Cont.**

Known **allergies**: \_\_\_\_\_

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

Please describe any **sensory impairments**: Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

**Blood pressure** reading: \_\_\_\_\_

Has **any illness** during the past 5 years resulted in impaired physical or mental health?

\_\_\_\_\_

**Hospitalization(s)** during the last 5 years? Y  N  Reason(s): \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Please indicate applicant's need for assistance with **activities of daily living**: \_\_\_\_\_

\_\_\_\_\_

Is the applicant **continent** of: Bladder Y  N  and Bowel: Y  N

Does the resident use any appliances or durable **medical equipment**:

Walker: Y  N  Cane: Y  N  Wheelchair: Y  N  Other: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Primary Physician's Signature**: \_\_\_\_\_

**Physician's Name Printed**: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

*Thank you for your assistance.*