Libby Bortz Assisted Living
5844 South Curtice Street
Littleton, CO 80120
Phone: (303) 347-9755 Fax: (303) 347-3064

Physician Evaluation

1) Patient Name: _____ DOB: _____

Height: _____ Weight: _____ Blood Pressure: _____

Nutritional Status: _____ Allergies: _____

Is the patient taking any nutritional supplements? ☐ Yes ☐ No

If yes, what supplements?

_____

2) List Significant Diagnosis/Medical Diagnosis

a. _____ f. _____

b. _____ g. _____

c. _____ h. _____

d. _____ i. _____

e. _____ j. _____

3) Physical and/or Sensory Limitations:

_____

3) Cognitive and/or Behavioral Status:

_____

3) In your professional opinion, can this individual's needs be met in a residential facility (assisted living facility) that is not a medical, nursing, or psychiatric facility?

_____

3) Is this resident able to safely leave the facility and travel throughout the community alone?

☐ Yes ☐ No

4) Is the resident bedridden? ☐ Yes ☐ No

Patient Name: _____

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8) Does this resident have a communicable disease that could be transmitted to other residents or staff? _____

9) Treatments/Therapies

To your knowledge is the patient receiving:

☐ Physical Therapy Name of Agency: _____

☐ Occupational Therapy Name of Agency: _____

☐ Speech Therapy Name of Agency: _____

☐ Other Home Health Services: Type of Services and Name of Agency:

_____

Is the patient utilizing oxygen? ☐ Yes ☐ No If yes, how many liters? _____

Name of oxygen company if known: _____

Is the patient on Coumadin? ☐ Yes ☐ No

If yes please complete the applicable statement:

☐ a) Primary Care Provider is responsible for monitoring the patient PT/INR.
PCP Name: _____

☐ b) How often? ☐ weekly ☐ monthly or other (how often) _____

☐ c) Is the patient diabetic? ☐ Yes ☐ No

☐ d) Primary Care Provider responsible for monitoring the patient glucose levels.
PCP Name: _____

☐ e) How often are glucose levels checked? ☐ weekly ☐ monthly
☐ other please indicate: _____

Please note that the staff of Libby Bortz Assisted Living Center do not perform services that include PT/INR, checking glucose levels, or administering any type of injection.

10) To your knowledge has the patient had an upper respiratory or gastrointestinal illness?

☐ Yes ☐ No If yes, when: _____

11) To your knowledge has the patient fallen in the past year?

☐ Yes ☐ No If yes, how often? _____

12) Does the patient appear to be oriented to person, place and time? ☐ Yes ☐ No

Patient Name: _____

13) To your knowledge, has this patient showed any signs of confusion? ☐ Yes ☐ No

If yes, please explain? _____

14) To your knowledge, has this patient ever wandered? ☐ Yes ☐ No

If yes, please explain incident: _____

15) Does this resident require 24-hour nursing or psychiatric care? If so, this resident is not appropriate, as this is not a skilled facility. _____

16) To your knowledge, does this patient have any history of mental illness or abnormal behaviors including hospitalization for this issue? ☐ Yes ☐ No If yes, in your opinion is this a current problem? Please explain:

_____

17) To your knowledge has this patient ever expressed suicidal ideation?

☐ Yes ☐ No If yes, please explain:

_____

18) Does the patient have any history of substance abuse? ☐ Yes ☐ No

If yes, please explain: _____

19) Is the patient continent of bladder? ☐ Yes ☐ No

Is the patient continent of bowel? ☐ Yes ☐ No

20) Does the patient require assistance with bathing? ☐ Yes ☐ No

21) Does the patient require any adaptive device to assist with ambulation, bed mobility, dressing or bathing? ☐ Yes ☐ No

If yes, type of adaptive equipment?

☐ Walker ☐ Bed Cane ☐ Wheelchair

☐ Cane ☐ Shower Chair/Bench ☐ Reacher

☐ Other: _____

Patient Name: _____

22) Does this resident pose a danger to him/herself or others? ☐ Yes ☐ No

23) Does this resident have any stage 2, 3, or 4 pressure sores? _____

24) Can this resident eat a regular diet? (Note: LBALC only offers a REGULAR diet-we cannot accommodate special needs of any kind. Diabetic residents are offered sugar-free desserts as an alternative to regular desserts. ☐ Yes ☐ No

25) What was the date that the patient was last seen by you? _____

26) When was the last history and physical exam? _____

27) Does the patient have a communicable disease? ☐ Yes ☐ No

28) Is the patient/resident safe to live unsupervised in an apartment at Libby Bortz Assisted Living Center? (The apartment consists of a large bedroom and private bathroom)
☐ Yes ☐ No

29) Is the resident capable of operating a motor vehicle? ☐ Yes ☐ No

THE PATIENT MUST BE CAPABLE OF SAFELY SELF ADMINISTERING MEDICATION WITHOUT THE ASSISTANCE OR OVERSIGHT OF ANOTHER PERSON. (MUST BE CAPABLE OF SETTING UP OWN MEDICATION REMINDER BOX, OR ADMINISTERING MEDICATION FROM A BOTTLE, ETC)

PHYSICIAN ORDER SHEET

Patient/Resident Name: (First) (Last) (Middle) Date Form Completed

_____

Generic equivalent is authorized ☐ Yes ☐ No

Routine medications include any over the counter medications, vitamins and supplements

(state diagnosis or rationale)

RX Name	Strength	Dosage	Route	Frequency	Diagnosis/Rationale for drug

PRN Medications	(☐May DC after 60 days for non-use)				

Please note all of the above needs to be complete and have a Physician Signature in order for the resident to move into Libby Bortz Assisted Living Center

- ☐ **Resident is capable of safely self administering medications.**
- ☐ **Physician feels and thereby orders that staff should administer and monitor medications.**

Physician Name (print): _____ Physician NPI #: _____

Physician Signature: _____ Date: _____

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