Physician's Report for Community Care Facilities

Note to Physician: The person specified below is a client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical, necessary to meet the needs of the individual client.

The Facilities do not provide professional nursing care. The information that you complete on this person is required by law to assist in determining whether the client is appropriate for admission to or continued care in a facility.

Client Information:

Name:	DOB:

Primary Diagnosis:			Secondary Diagnosis:	
Age:	Height:	Sex:	Weight:	B/P:

In your opinion does this person require skilled nursing care: ☐ YES ☐ NO

Tuberculosis Examination Results: ☐ Active ☐ Inactive ☐ None

Date of Last TB test:

Type of TB test used:

Treatment/Medication ☐ YES ☐ NO If YES, list below:

Other Contagious/Infectious disease: ☐ YES ☐ NO If YES, list below:

Treatment/Medication: ☐ YES ☐ NO If YES, list below:

Allergies: ☐ YES ☐ NO If YES, list below:

Treatment/Medication: ☐ YES ☐ NO If YES, list below:

Ambulatory Status of client: ☐ Ambulatory ☐ Non-ambulatory

Physical Health Status: ☐ Good ☐ Fair ☐ Poor
Comments:

	Yes	No	Assistive Device	Comments
1. Auditory Impairment				
2. Visual Impairment				
3. Wears Dentures				
4. Special Diet				
5. Substance Abuse problem				
6. Bowel Impairment				
7. Bladder Impairment				
8. Motor Impairment				
9. Requires continued bed care				

Mental Health Status: ☐ Good ☐ Fair ☐ Poor
Comments:

	No Problem	Occasional	Frequent	If problem exists: provide Comment
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to Communicate				

Capacity for Self Care : ☐ Yes ☐ No
Comments:

	Yes	No	Comments
1. Able to care for all personal needs			
2. Can take their own medications			
3. Needs constant medication supervision			
4. Currently taking prescribed medications			
5. Bathes Self			
6. Feeds self			
7. Cares for his/her own toilet needs			
8. Able to leave facility unassisted			

Note: On a separate Sheet Provide Medication Order[Prescribed and Over the Counter].

Physician's Signature: _____

Referring Agency: _____

Date:_____