



Annual Medical Evaluation Form

*This form **MUST** be filled out and signed by the examining physician, NP, or PA, a stamped signature or practice stamp will not be accepted as substitution for the practitioner's signature.*

Name: _____ Date: _____

Address: _____

Age: _____ DOB: _____ Sex: Male / Female

*In the event of an emergency this client should be transported to _____ hospital. (This information will be shared with the ambulance crew, however final destination is at their discretion based upon patient condition at the time of transport.)

*Does this client have a Living Will or Advanced Directive: ___ Yes, (please attach a copy) ___ No

Health History

Neurologic: _____

Cardiovascular: _____

Respiratory: _____

GI/GU: _____

Endocrine: _____

Other: _____

Surgical History: _____

Allergies to Foods: _____

Allergies to Medications: _____

Annual Medication Reconciliation:

(Please list ALL medications this client takes both prescribed and over-the-counter)

_____ This client is not currently on any medications.

Medication	Dosage	When is it taken?	Why is it taken?

- Please attach a list for additional medications.

Assessment

T: _____ **HR:** _____ **BP:** _____ **Resp:** _____ **Hgt:** _____ **Wgt:** _____

Physical Assessment	Check if normal	Describe Abnormalities
Head/Neck		
Eyes- cataracts, glasses, glaucoma		
Ears- Hearing aids, deaf		
Nose/Throat		
Mouth/Teeth/Gums		
Speech		
Cardiovascular/edema		
Lungs- Oxygen Use		
Abdomen- G-Tube		
Extremities- Ambulation		
Skin		
Neuro		

Assessment continued

**Any other medical information pertinent to diagnosis and treatment of client in the event of an emergency.
Please include copies of pacemaker and medical device cards when applicable:

Immunization Dates

Tetanus/DPT: _____ (Mandatory every ten years for clients under the age of 65.)

T.B. Mantoux: (Mandatory every 2 years)

Tuberculin Test Date Applied	Arm Used For Testing	Manufacturer / Expiration	Signature/Credentials
Date Read	Induration (+/-)	Results (mm)	Signature/Credentials

Note: ONLY a MD/DO, NP, PA, RN, or LPN is permitted to read the TB Test

*If Positive or recent exposure please list Chest X-ray results, treatments, and dates: _____

The following are not mandatory; however, please include dates if applicable:

Hepatitis B: _____ / _____ / _____ Hepatitis A: _____ / _____

Influenza: _____ Pneumonia: _____

This client is clear and free of all communicable diseases. ___ Yes ___ No

If No please indicate disease and any specific precautions that must be taken in order to prevent the spread of disease to other staff and clients: _____

Annual Order Update

*Special Nutritional Orders: (i.e. diet, pureed, chopped, thickened liquids-consistency, tube feeding protocol)

**Use of Medical treatments or therapies recommended: _____

Annual PRN Medication Orders

Clients Name: _____

In addition to regularly schedules daily medications listed on page one of the medical evaluation this individual may be given the following medications as prescribed: (Note: No intravenous, intra muscular, or subcutaneous injections can be given while at the center due to lack of continuous nursing coverage.)

For Which Symptoms	Medication Name	Dosage & Route	Frequency
Pain and Fever			
Cold and Cough			
Hypoglycemia **			
Seizure Activity			
Other:			
Other:			
Other:			

* Tylenol and Advil are kept at center for general use.
**15 Gram Carbohydrate Tablets kept at the center for known diabetics.

Over-the-Counter medications that are contra-indicated for this patient include:

Permission is granted by the below signed practitioner to administer these medications on an as needed basis only as specified above. It remains the responsibility of the client’s family or caregiver to supply Bon Homie Ltd. with these medications as needed based on the client’s condition.

Additional prescriptions for over-the-counter medications being utilized for sporadic care may be faxed to Bon Homie Ltd. either on this form or on an original prescriptive pad including the above information to (610)792-8820.

_____ Practitioner’s Name Printed	_____ Sign
_____ DEA #	_____ Date
_____ Office Address	
_____ Office Phone Number	_____ Fax



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Medically Necessary Assistive Devices Order Sheet

ADULT DAILY LIVING CENTER

Client's Name: _____ Date of Birth: _____

Medical Diagnosis Requiring Use of Device: _____

Reason for Ambulatory Devices:

- Cane: To be used for *all* ambulation
 Only to be used when: _____
 Standard Care Quad Cane
- Walker: To be used for *all* ambulation
 Only to be used when: _____
 Standard Walker Wheeled Walker
- Wheelchair: To be used for *all* ambulation
 Only to be used when: _____

Reason For Postural /Orthopedic Support Devices:

- Use with Wheelchair: Lap Belt Chest Straps Head Rest
 Abductor Pillow Wedges: Location(s): _____
 Tray Table
Above to be used: Always when in Wheelchair
 During vehicle transportation only.
 When not at a table
 To Aid Client during activities only.
 Other: _____
- Stander: May use stander
(Must weigh <200lbs.) _____ minutes
 _____ time / week
 Additional Ortho. Equipment required (i.e. AFOs) _____
- Other: AFO Type: _____ Location: _____
(please specify body Other: _____
parts, use, & _____
parameters) Prosthetic Device Type: _____ Location: _____
Other: _____
 Spinal Brace Type: _____ When: _____
Other: _____
 Any Other Orthopedic Support Devices: _____

Reason for Medical/Safety Assistive Devices:

- Helmet: Always During Transfers Only
 During Vehicle Transportation Only During Seizure Activity Only
 Other Specification: _____
- Vagal Nerve Immediately after seizure activity is recognized
Stimulator: Other Specification: _____
Any Other: Specification: _____

_____	_____
Practioner's Name (Printed)	Signature
_____	_____
DEA #	Date

Office Address	
_____	_____
Office Phone Number	Office Fax Number



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Physician's Recommendation on care for ICF/MR clients:

To the best of my knowledge, this patient's medical condition and related needs are as indicated in the proceeding medical form. I recommend that the services and care to meet these needs can be provided at the level of care indicated.

_____ ICF/MR Care (Services to be provided at home or in an intermediate care facility for the mentally retarded.)

Physician's Signature

Date