MEDICAL HISTORY AND ADMISSION EXAMINATION

MONTANA VETERANS' HOME

This form need to be completed and signed by your current physician. Please be sure all requested information is supplied, as the Home will not be able to review or admit you until information is received.

LAST NAME FIRST NAME

ATTENDING PHYSICIAN

ADMISSION DIAGNOSIS (STATE FULLY)

PAST IMMUNIZATION HISTORY

*PPD DATE_________________________ CONVERTED: YES ☐ NO☐ TREATED YES☐ NO☐

*PPD WILL BE DONE NO LATER THAN 4 WEEKS PRIOR TO ADMISSION. IF UNABLE TO RECEIVE SKIN TESTING, A CERTIFICATION SIGNED BY APPLICANT'S PHYSICIAN SHOWING THAT HE/SHE IS FREE OF TB MUST BE RECEIVED OR APPLICANT WILL NOT BE ACCEPTED FOR ADMISSION TO THE MONTANA VETERANS' HOME.

SUMMARY OF PRESENT ILLNESSES

SUMMARY OF PREVIOUS ILLNESSES

IF APPLICANT HAS SEIZURE DISORDER, DESCRIBE FREQUENCY AND NATURE OF SEIZURES

DOES APPLICANT HAVE CARDIOVASCULAR PROBLEMS YES ☐ NO☐

IF YES, EXPLAIN STAGE____

DOES APPLICANT HAVE A PACEMAKER YES ☐ DATE:_____________________ NO☐ DATE OF LAST EKG

DESCRIBE IF DEMENTIA OR MENTAL ILLNESS PRESENT

DOES APPLICANT HAVE A CONTAGIOUS DISEASE IN COMMUNICABLE STAGE? YES ☐ NO ☐

IF YES, EXPLAIN____

HAS APPLICANT EVER HAD AND/OR BEEN TREATED FOR TB? YES ☐ NO ☐

IF YES, EXPLAIN____

HAS APPLICANT EVER HAD AND/OR BEEN TREATED FOR MRSA, VRE, CRE, ESBL OR C. DIFFICILE? YES ☐ NO ☐

IF YES,

EXPLAIN____

____

____

IF YES PLEASE NOTIFY INFECTIN CONTROL AND/OR DIRECTOR OF NURSING AT 406-892-3256, PRIOR TO ADMISSION!!!

LIST MEDICATIONS PRESENTLY BEING PRESCRIBED FOR APPLICANT

MEDICATION	DOSAGE	DIAGNOSIS

LIST ANY ALLERGIES

CURRENT DIET – INCLUDE CALORIC REQUIREMENTS AND ANY SPECIFIC RESTRICTIONS

STATE TYPE AND DEGREE OF DISABILITY, IF ANY

PROGNOSIS AND GOALS FOR REHABILITATION

DOES APPLICANT USE ALCOHOL? CURRENTLY: YES ☐ NO ☐ HISTORY OF USE: YES ☐ NO ☐
IF YES, HOW FREQUENTLY? ☐ WEEKLY ☐ 2-3 TIMES/MONTH ☐INFREQUENTLY
HAS APPLICANT ATTENDED AN ALCOHOL TREATMENT PROGRAM? YES ☐ NO ☐
IF YES, AS INPATIENT ☐ OUTPATIENT ☐ DATES(S):

HAS APPLICANT BEEN DIAGNOSED WITH A MENTAL ILLNESS? YES ☐ DIAGNOSIS: NO ☐
HAS APPLICANT BEEN TREATED FOR A MENTAL ILLNESS? YES ☐ NO ☐
INPATIENT: YES ☐ DATE(S)____
OUTPATIENT: YES ☐ DATE(S)____

DOES APPLICATN SMOKE? YES ☐ NO ☐ CIGARETTES ☐ PIPE ☐ CIGARS ☐

ADDITIONAL MEDICAL INFORMATION:

ANY RECOMMENDATIONS, ETC.

ACTIVITIES OF DAILY LIVING ASSESSMENT

FUNCTIONAL CAPABILITIES	*ABLE*	*UNABLE*
Changes own position	☐	☐
Can sit by self	☐	☐
Able to walk upstairs	☐	☐
Able to walk downstairs	☐	☐
Can bear weight on feet	☐	☐
Circle (right), (left), (both)		
Get into and out of bathtub	☐	☐
Can make own bed	☐	☐
Walk independently	☐	☐
Walk with aid of appliances	☐	☐
Identify crutches, cane, walker, etc		
Get out of chair or wheelchair without help	☐	☐
Get in chair or wheelchair without help	☐	☐
Go through doors independently	☐	☐

FUNCTIONAL CAPABILITIES	*ABLE*	*UNABLE*
Attend to personal hygiene	☐	☐
Groom self: Face and hands	☐	☐
Bathe	☐	☐
Brush teeth	☐	☐
Comb hair	☐	☐
Get in and out of bed	☐	☐
Transfer to/from toilet by self	☐	☐
Feed self	☐	☐
Dress/undress self	☐	☐
Toilet self	☐	☐
Shopping	☐	☐
Money management	☐	☐
Self medication	☐	☐

Order for admission: ☐ Yes ☐ No Check one: ☐ Intermediate care ☐ Skilled care ☐ Domiciliary

Physician's signature____

Address ____

Date of examination____