GOLDEN AGE HOME

Medical Admission Form

Name: _____ _____ _____
Last First Middle

Address: _____ _____ _____
Street or Box Number City State

Date of Birth: _____ Age: ___ Sex: ___ Medicare Number: _____

Social Security Number: _____ Medicaid Number: _____

Supplemental Insurance: _____ Policy Number: _____

Admission Date (to GAH): _____

MEDICAL INFORMATION

(Primary Physician required to complete this section)

I have examined this resident on the _____ day of _____, 20 _____.
(By Assisted Living regulations a physical exam must be done 30 days prior to GAH admission or within 14 days afterwards and annually during resident's stay at AL facility.)

After examination, it has been determined that, (1) the resident is not harmful to himself/herself or to others, (2) the resident is capable of maintaining himself/herself in an Assisted Living Facility.

Physician: _____ _____ _____
Signature Printed Name Date

Diagnoses: _____
_____

Health Conditions:
_____
_____

Mental Health Status: _____

Medications: _____
_____

Possible Side Effects:
_____
_____

Allergies:_____

Date of last hospital stay _____ Reason _____
Name of Hospital_____ City _____
Length of Stay _____

Date of Last

Influenza Vaccine: _____ Pneumonia Vaccine: _____ Mammogram: _____
Tuberculosis Test: _____

Assisted Devices

Wheelchair _____ Walker/Cane _____ Electric Scooter _____ Transfer ability _____
Hearing Aides _____ Dentures _____ Glasses _____
Pacemaker _____ Other hardware _____

Special Treatments & Procedures:

_____

_____

Blood Pressure Checks	❑ Yes	❑ No	Frequency _____
Medication Assistance Needed	❑ Yes	❑ No	
Blood Sugar Checks	❑ Yes	❑ No	Insulin? _____
Weight Checks	❑ Yes	❑ No	Frequency _____
Orders Attached	❑ Yes	❑ No	For _____
Special Diets	❑ Yes	❑ No	_____
Driving	❑ Yes	❑ No	

Preventive Health Needs:

_____

Reason for Admission to ALF: _____

Physician Notes:

_____

_____

_____	_____	_____
Golden Age Home Representative	Resident or Responsible Party	Date