

Knik Manor Assisted Living

PHYSICIAN MEDICAL REPORT

Wasilla Area Seniors, Inc will provide assisted living services to the Residents of Knik Manor Assisted Living facility 24 hours, 7 days a week which includes assistance with medication, meals, basic activities of daily living (i.e. bathing dressing, grooming) and to assist clients with making medical related appointments and transportation to appointments. Health Care monitoring will cover blood pressure and other vital signs, reporting notable changes in resident to Health Care Providers. We have a Licensed Nurse as Resident Manager working 40 hours per week and on call. She will teach and delegate to staff in accordance with the Alaska State Board of Nursing Act. Our staff will assist clients in arranging outside/community services such as home health, physical therapy occupational therapy

In your professional opinion, does your Patient's needs require Assisted Living?

Resident's Name _____ YES _____ NO _____

Physician's Signature

____/____/____
Date

If you have any questions or concerns about our services please feel free to call any time Monday – Friday, between the hours of 8:00am and 4:00pm at 357-2116.

If you decide our facility is right for your patient please fill out and return the following pages to:

Wasilla Area Seniors, Inc.
1301 Century Circle
Wasilla, Alaska 99654

Thank You For Your Time
Vanessa Gittlein^{PM}, RM
Resident Manager/Administrator

Knik Manor Assisted Living
Physician's Medical Report

NAME: _____ D.O.B: ___/___/___ Sex: M ___ F ___

Medical History And Current Medical Problem (attach dictated summary, if preferred)
(Minimal five years history preferred)

Diet: Regular No Added Salt No Added Sugar Soft Texture

TUBERCULOSIS CLEARANCE: (must be read prior to move in)

Results	Type	____/____/____ Date of test	____/____/____ Date of reading
---------	------	--------------------------------	-----------------------------------

Other Health Care Providers from whom the individual receives care:

IF THE FACILITY DOES NOT RECEIVE A COPY OF THE RESIDENT ADVANCE DIRECTIVE, LIVING WILL, OR A NON-RESUSCITATION ORDER AND IF NEEDED C.P.R. WILL BE STARTED AND MAINTAINED UNTIL EMERGENCY SERVICES ARRIVES.

_____ Patient/Legal Representative	_____ Date	_____ Physician's Signature	_____ Date
---------------------------------------	---------------	--------------------------------	---------------

Orders for medications must be written in script form and must have a diagnosis.

Knik Manor Assisted Living
Physician's Medical Report

Medication	Dose	Frequency	Route	Diagnosis
Tylenol				
ASA				
Ibuprofen				

Medication/treatment of choice for Constipation: _____

Medication/treatment of choice for Diarrhea: _____

May resident receive high fiber whole bran cereal, applesauce, and prune juice for constipation? Yes__ No__?

May resident receive high fiber whole bran cereal for diarrhea? Yes_ No__?

If resident is diabetic please include: Carb, Protein, Fat exchanges, or grams per meal.

Carbs breakfast ____, snack ____, lunch ____, per day ____.

Protein _____

Fats _____

In occurrence of an abrasion, lacerations not requiring medical attention, or minor skin tears, the staff of Wasilla Area Seniors Inc Assisted Living Services may clean area with normal saline, apply antibiotic ointment (if not countered indicated) to affect area and apply dressing/band-aid of choice. YES _____ NO _____

Alcohol: Resident may use alcohol in their apartment on an occasional basis.

YES _____ NO _____

These orders are effective for 90 days, unless otherwise indicated. After 90 days the Resident Manager will contact the Physician with an updated Physician Order List, which will be reviewed, signed and returned to the facility. For quality assurance and privacy issues this facility will only accept orders via facsimile or U.S. mail.

Physician's Signature

____/____/____
Date

Resident's Name _____

Knik Manor Assisted Living
Physician's Medical Report

Resident's Name: _____

MOVE-IN CRITERIA

Physician signed orders that state resident needs/or will benefit by living in Assisted Living including:

1. The resident's medical history in summary for the last 5 years and current list of resident's medication with dosage, frequency, and category as listed in above form.
2. Medical conditions listed and certified to be stable and predictable.
 -
 -
 -
 -
 -
 -
 -
3. Resident demonstrates stable behavior.
4. The resident has the ability to participate in directing care needs.
5. The resident is able to use Emergency call devices to access assistance.

Physicians signature

Date