The Granville
Assisted Living Center

The Granville Assisted Living Center
1325 Vance Street
Lakewood, CO 80214
(303) 274-4400
Fax (303) 274-4100
www.TheGranvilleAssistedLiving.com

PHYSICIAN EVALUATION

Date: ____________________________

RE: ____

Dear Dr. ____

Your patient has applied for residency at The Granville Assisted Living Center. This Center will provide limited, supplemental, non-medical service.

The staff at this center provides the following services:

1. Three meals a day plus snacks
2. Weekly housecleaning and laundry
3. Medication administration
4. Minimal dressing and bathing assistance

In order to reside here, residents must:

1. Be able to perform activities of daily living with assistance if needed.
2. Be willing to accept necessary assistance from staff.
3. Be able to maintain an odor free environment and person, independently.

In order to ensure that our residents are able to take advantage of this living environment, accurate health information is necessary. Please complete the attached questionnaire as accurately and completely as possible.

Your patient's application will be considered when we have received your completed forms. Your prompt assistance is greatly appreciated. If you have any questions, please call me at 303-274-4400.

Sincerely,

Jaime Tafoya

Jaime Tafoya
Medication Coordinator

The Granville
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PHYSICIAN EVALUATION

1. Patient's Name: ____

DOB ______________ Height ______________ Weight ____________________

Blood Pressure ____

Nutritional Status ____

2. List Significant Diagnosis/Medical Problems: ______________________

Pleases include ICD-10 code

3. Does patient suffer from any communicable diseases? **Yes** ☐ **No** ☐

If yes, explain: ____

4. Medications-Routine medications including prescription and over the counter drugs:

Name of Drug	Dosage	Frequency	Reason

List Known Rx Allergies: ____

____

____

If patient is utilizing Oxygen, please provide the order: **Yes** ☐ **No** ☐

List Any Known Food Allergies: ____

Please list any drugs that the patient may have on a **PRN basis**:

Name of Drug	Dosage	Frequency	Reason

5. Treatments/Therapies: ____

____

6. Can this patient safely self-medicate? **Yes** ☐ **No** ☐

7. To your knowledge, how often has this patient fallen in the past year? ____________________

____

8. Does this patient appear to be oriented to person, place and time? **Yes** ☐ **No** ☐

9. To your knowledge, has this patient had any history of confusion? **Yes** ☐ **No** ☐

If yes, please explain ____

____

10. To your knowledge, has this patient had a history of wandering? **Yes** ☐ **No** ☐

11. To your knowledge, has this patient had any history of mental illness or abnormal behavior?
Yes ☐ **No** ☐

If yes, please explain ____

____

____

____

12. Does this patient have a history of any drug or alcohol abuse? **Yes** ☐ **No** ☐

If yes, in your opinion, is this a current problem? **Yes** ☐ **No** ☐

13. Is this patient in control of bladder? **Yes** ☐ **No** ☐

14. Is this patient in control of bowel? **Yes** ☐ **No** ☐

15. Does this patient require assistance with the following (please check):

Bathing ☐ **Mobility** ☐ **Eating** ☐ **Dressing** ☐

Daytime Toileting ☐ **Nighttime Toileting** ☐

Other ____

16. Does this patient require the use of any device to assist with ambulation, such as a cane, walker, crutches or wheelchair? **Yes** ☐ **No** ☐

If yes, please indicate ____

17. What was the date this patient was last seen by you? ______________________________

18. How long has this patient been under your care? __________________________________

19. Does this patient have any restrictions in their ability to participate in the programs activities?
Yes ☐ **No** ☐ If yes, please explain ___________________________________

____

____

20. Is this patient an appropriate applicant for an assisted living center? **Yes** ☐ **No** ☐

Patient: ____

Physician Signature: ____ Date: ____________

Physician Printed Name: ____

Address: ____

Phone: ____

Fax: ____

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