Marillac Residence
Residential Care Community

Physician's Statement: To be completed by Physician

Patient Name: _____ DOB: _____

Home Address: _____

Date of most recent physical exam: _____

Diagnoses, Active medical problems: _____

_____

_____

_____

Has the applicant had any of the following diseases or conditions? Please circle **Yes** or **No**. If **Yes**, please provide additional information that will help in service planning.

Allergies: YES NO _____

Cancer: YES NO _____

Diabetes: YES NO _____

Heart Disease: YES NO _____

Hip or Other Fractures: YES NO _____

Incontinence: YES NO _____

Respiratory Disease: YES NO _____

Skin Conditions: YES NO _____

Stroke: YES NO

_____

Wound Care: YES
NO_____

History of cognitive difficulties, substance abuse, psychosocial issues including the presence of disruptive behaviors or behaviors which may present a risk to the health and safety of the resident or others:

_____

_____

_____

_____

Treatments: (specific orders and frequency) Special Needs:

_____

_____

_____

Any dietary restrictions? Yes No (if Yes, please specify)

_____

Does applicant smoke: Yes No

Physical Exam Data: Weight: _____ Height: _____

Blood Pressure: _____ Temp.: _____

Mantoux: Yes / No Date of last test: _____

Other: _____

Date of Most Recent Flu Vaccine: _____ If refused, reason: _____

Date(s) of Covid-19 vaccination: 1st _____ 2nd _____ 3rd _____

Manufacturer of Vaccine: _____ If Covid Vaccine Refused, reason: _____

Please describe any sensory impairments:

Visual: _____

Hearing: _____

Speech: _____ **Please**

check the appropriate status for each of the following:

1. **Medication Administration:**
   _____ able to self-manage and self-administer all medications
   _____ needs supervision only to self-administer all medications
   _____ needs supervision and some assistance to self-administer all medications
   _____ needs medication administration by licensed personnel

2. **Eating**: _____ fully independent _____ needs supervision _____ needs assistance

3. **Nutrition Management & Compliance**: ___ fully independent ___ needs supervision ___ needs assistance

4. **Dressing:** _____ fully independent _____ needs supervision _____ needs assistance

5. **Grooming**: _____ fully independent _____ needs supervision _____ needs assistance

6. **Showering / Bathing**: _____ fully independent _____ needs supervision _____ needs assistance

7. **Toileting:** _____ fully independent _____ needs supervision _____ needs assistance

8. **Ambulation:** _____ fully independent _____ needs supervision _____ needs assistance

9. **Transferring:** _____ fully independent _____ needs supervision _____ needs assistance

Does the Applicant use any of the following appliances or durable equipment?

Walker: Yes No Cane: Yes No Wheelchair: Yes No CPAP: Yes No

Other Equipment (please specify): _____

Medications:

Start Date	Medication dosage, Method of Administration, Frequency Please indicate appropriate time of day for each medication	Any Other Comments

Physician Signature: _____ Date: _____

Physician Name: _____

Address: _____

Telephone: _____ Fax: _____

By signing this form, I attest that my patient is medically and socially appropriate for Level IV Rest Home care.

Physician Order required for admission to Marillac Residence, a Level IV Rest Home, licensed by the Department of Public Health.

105 CMR 150.003 Patients or residents shall be admitted only on the written order of a physician, physician assistant or nurse practitioner who designates the placement as medically and socially appropriate.

Please return the completed form to: **Marillac Residence**
Attention: Admissions Coordinator
125 Oakland Street
Wellesley Hills MA 02481-5338

Telephone: 781-237-2161
Fax: 781-997-1147