Healthcare Practitioner Form

Date: _____ dd / mm / yyyy

Name: _____

Gender: _____

Date of birth: _____ dd / mm / yyyy

Emergency contact name: _____

Emergency contact number: _____

Emergency contact relationship: _____

CURRENT MEDICAL AND PSYCHIATRIC HISTORY

Indicate recent changes in health or behavioral status, hospitalizations, suicide attempts, falls, etc, within 6 months.

MEDICAL HISTORY

Describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

ALLERGIES

List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem.

COMMUNICABLE DISEASES

Is the patient free from communicable TB and other active reportable airborne communicable disease(s)?

◯ Yes ◯ No

Indicate the disease: _____

List the tests done to verify the patient is free from active communicable disease.

DRUG ABUSE HISTORY

Does the patient have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?

Substance: OTC, non-prescription medication abuse or misuse

Recent (within 6 months):

◯ Yes ◯ No

History:

◯ Yes ◯ No

Abuse or misuse of prescription medication or herbal supplements

Currently:

◯ Yes ◯ No

Recent (within 6 months):

◯ Yes ◯ No

History of non-compliance with prescribed medication

Currently:

◯ Yes ◯ No

Recent (within 6 months):

◯ Yes ◯ No

Describe misuse or abuse:

RISK FACTORS FOR FALLS AND INJURIES

Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply)

- ☐ Osteoporosis
- ☐ Pain
- ☐ Assistive devices
- ☐ Foot deformity
- ☐ Impaired balance
- ☐ Parkinsons
- ☐ Gait problem
- ☐ Confusion
- ☐ Orthostatic hypotension
- ☐ Other

SKIN CONDITIONS

Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders.

SENSORY IMPAIRMENTS AFFECTING FUNCTION (CHECK ALL THAT APPLY)

Left ear:

- ☐ Adequate
- ☐ Poor
- ☐ Deaf
- ☐ Uses corrective aid

Right ear:

- ☐ Adequate
- ☐ Poor
- ☐ Deaf
- ☐ Uses corrective aid

Vision:

- [ ] Adequate
- [ ] Poor
- [ ] Uses corrective aid
- [ ] Blind
- [ ] Left
- [ ] Right

TEMPERATURE SENSITIVITY

Sensitivity?

◯ Normal ◯ Heat ◯ Cold

Decreased sensation to: _____

CURRENT NUTRITIONAL STATUS

Height (inches): _____ **Weight (lbs):** _____

Weight change (gain or loss) in the past 6 months:

◯ Yes ◯ No

How much weight change?: _____

Is there evidence of malnutrition or risk for undernutrition?

◯ Yes ◯ No

Is there evidence of dehydration or a risk for dehydration?

◯ Yes ◯ No

Any medical or dental conditions affecting: (Check all that apply)

- [ ] Chewing
- [ ] Swallowing
- [ ] Eating
- [ ] Pocketing food
- [ ] Tube feeding

MEDICATIONS

Medication(s): Include dosage route, frequency, duration.

What diagnoses are currently being treated by this medication?

Prescriber signature:

Date: _____ dd / mm / yyyy **Phone:** _____

Address: _____

SIGNATURES

Patient:
Date: _____ dd / mm / yyyy

Healthcare provider:
Date: _____ dd / mm / yyyy