

Physician Admission Form



Resident Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Allergies: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Primary Diagnosis Code: \_\_\_\_\_

**\*\*Please attach current problem list**

**MEDICATION ADMINISTRATION**

Is the resident diabetic?            YES            NO  
  
   Insulin dependent            YES            NO  
   Sliding Scale Insulin        YES            NO  
   Blood glucose testing        QD            BID            TID            QID

Can the resident self administer their medications?        YES            NO

Can the resident keep medications at their bedside?        YES            NO

If yes, please list which ones: \_\_\_\_\_

Is the resident taking any blood thinners?            YES            NO

If yes, indicate the date of the last PT/INR: \_\_\_\_\_

Any medications which require AIMS assessments?        YES            NO

If yes, please list: \_\_\_\_\_

Any PRN Psychoactive medications?            YES            NO

If yes, please list: \_\_\_\_\_

**\*\*Please attach current medication list**

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DIETARY NEEDS

Special Dietary Considerations: \_\_\_\_\_

Food Allergies or Restrictions: \_\_\_\_\_

PHYSICAL FUNCTIONING

(Please check the appropriate response)

	<b>Independent</b>	<b>Assistance</b>	<b>Assistive Devices Used:</b>
Transfers	_____	_____	_____
Ambulation	_____	_____	_____
Toileting	_____	_____	_____
Dressing	_____	_____	
Hygiene	_____	_____	
Showers	_____	_____	

COGNITIVE FUNCTIONING

Does resident have a current diagnosis of dementia or alzheimers disease?      YES      NO

Is the resident at risk for elopement?                      YES      NO

    If yes, should resident wear a wanderguard bracelet?      YES      NO

IMMUNIZATIONS

Flu Vaccine	Pneumovac	Tuberculosis	Tetnus
_____	_____	_____	_____

COVID-19: \_\_\_\_\_

Date 1st	Date 2nd	Type
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CODE STATUS

(Please circle)

DNR

CPR

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date