Resident Name: **DOB:**

Height: **Weight:** **Allergies:**

Primary Care Physican: _____

Address:

Phone:

Fax:

DIAGNOSIS | MEDICATION LIST

Primary Diagnosis Code: _____

Please attach current diagnosis and medication 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: _____

www.brownway.com
OR Facebook:
@brownwayresidentialcarehome

328 School Street
Enosburg Falls, VT 05450

(P) 802-933-2315
(F) 802-933-7997

Owner/Operators
John Amanda St.Cyr
January 2022

DIETARY NEEDS

Special Dietary Considerations: _____

Food Allergies or Restrictions: _____

PHYSICAL FUNCTIONING

(Please check the appropriate response)

	Independent	**Assistance**	**Assistive Devices Used:**
Transfers	_____	_____	_____
Ambulation	_____	_____	_____
Toileting	_____	_____	_____
Dressing	_____	_____	
Hygeine	_____	_____	
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 Booster Type

CODE STATUS (Please Circle)

DNR | CPR Please send copy of advanced directive, Power of attorney and/or COLST

_____ _____

Provider Signature Date

Please return to Brownway Residence as soon as completed. A decision cannot be made without this returned.

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