

### REPORT OF RESIDENT PHYSICAL EXAMINATION

(Examination is to be completed by an independent physician within 30 days prior to the date of admission. Report is to be kept as part of the person's permanent record.)

NAME

DATE OF PHYSICAL EXAMINATION:

ADDRESS

TELEPHONE

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

BP: \_\_\_\_\_

Significant Medical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General physical condition, including systems review as is medically indicated:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies (food, medicine, or other):

\_\_\_\_\_  
\_\_\_\_\_

Is this person:

\_\_\_ **Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such resident may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate).**

\_\_\_ **Nonambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).**

Does this individual have any of the following conditions or care needs?

Name \_\_\_\_\_

Condition/Care Need	Yes	No	Comment
Ventilator dependency			
Dermal ulcers III and IV			If stage III is ulcer healing?
Intravenous therapy or injections directly into the vein			If intermittent therapy please note and indicate expected time period.
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission			
Psychotropic medications without appropriate diagnosis and treatment plans			
Nasogastric tubes			
Gastric tubes			If yes, is person capable of independently feeding himself and caring for the tube?
Presents imminent physical threat or danger to self or others			
Requires continuous licensed nursing care			

Name \_\_\_\_\_

Diagnosis or significant problems:

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Recommendations for care:

Medications:

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Diet: \_\_\_\_\_

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Therapy: \_\_\_\_\_

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
(Please print or type physician's name here)

Address (Street, City, State, Zip Code)

\_\_\_\_\_

Telephone: \_\_\_\_\_