PHYSICIAN'S REPORT
FOR CLIENT APPLYING FOR ADMISSION TO HOPE HOUSE

NOTE TO PHYSICIAN: The person specified below is a resident/client of or an applicant for admission to Hope House. Hope House currently provides a basic level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual/residents/clients. The information you provide about this person is required to assist in determining whether the person is appropriate for care in this facility.

HOPE HOUSE DOES NOT PROVIDE PROFESSIONAL NURSING CARE

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative.)

NAME		TELEPHONE:
ADDRESS:		SOCIAL SECURITY NUMBER
NEXT OF KIN:	Relation to:	Contact Number:
PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	**Contact Number**	

PATIENTS DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS				
SECONDARY DIAGNOSIS				LENGTH OF TIME UNDER YOUR CARE
AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE _____ YES _____ NO
TUBERCULOSIS EXAMINATION RESULTS ACTIVE ☐ INACTIVE ☐ NONE ☐				DATE OF LAST TB TEST:
TYPE OF TB TEST USED:				TREATMENT/MEDICATION: ☐ YES ☐ NO IF YES, LIST BELOW

OTHER CONTAGIOUS DISEASES	TREATMENT/MEDICATION:
A) ☐ YES ☐ NO IF YES, LIST BELOW	B) ☐ YES ☐ NO IF YES, LIST BELOW
ALLERGIES	TREATMENT/MEDICATION:
C) ☐ YES ☐ NO IF YES, LIST BELOW	D) ☐ YES ☐ NO IF YES, LIST BELOW

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ YES ☐ NO

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

PHYSICAL HEALTH STATUS: GOOD FAIR POOR

COMMENTS:

	YES	NO (CHECK ONE)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual Impairment				
3. Wears Dentures				
4. Special Diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

MENTAL HEALTH STATUS: GOOD FAIR POOR

COMMENTS:

	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

CAPACITY FOR SELF CARE: YES NO

COMMENTS:

	YES	NO (CHECK ONE)	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			

11.	Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:	
Conditions: Headache, Constipation, Diarrhea, Indigestion, Others (specify condition) _____ _____	**OVER-THE-COUNTER MEDICATION(S)** _____ _____

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY THE CLIENT/RESIDENT:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO: HOPE HOUSE
P.O. BOX 1510
PAGO PAGO, AMERICAN SAMOA 96799

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED RESPRESENTATIVE

SIGN HERE:	**PLEASE PRINT:**
ADDRESS:	**DATE:**