Fax to: # 978-744-1516

## The Brookhouse Home for Women 180 Derby Street Salem, MA 01970

## **Medical Report for Residency**

| The patient known to your care has applied for residency at Brookhouse Home in Salem, Ma. In order to process her application, we need the following health information. Please complete and return to Brookhouse Home with a copy of last physical exam. |                |  |
|---|----------------|--|
| Name:   | Date of Birth: |  |
| Medical and Psychiatric Diagno  | ses:           |  |
| •   |                |  |
| •   |                |  |
| Significant History/Hospitalizati   | ions:          |  |
| •   |                |  |
|   |                |  |
| Current Medication Regimen:  •  |                |  |
| •   |                |  |
| •   |                |  |
| •   |                |  |

| •  |  |
|--|--|
| •  |  |
|  |  |
|  |  |
| Physical Impairments:  |  |
| Vision:  |  |
|  |  |
| Hearing:   |  |
| Mobility:  |  |
| •  |  |
| Current Smoker: Yes or No  |  |
|  |  |
| Level IV Rest Home.  |  |
| Level IV Rest Home.  |  |
| Level IV Rest Home.  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Nutritional Status:  |  |
| Nutritional Status:  Current Status:                                       |  |
| Nutritional Status:  |  |
| Nutritional Status:  Current Status:  Current Diet:                        |  |
| Nutritional Status:  Current Status:  Current Diet:                        |  |
| Nutritional Status:  Current Status:  Current Diet:  IBW:  Activity Level: |  |
| Nutritional Status:  Current Status:  Current Diet:  IBW:                  |  |

| Short and Long Term Health C  | <u> Goals:</u>         |                                      |
|---|------------------------|--------------------------------------|
|   |                        |                                      |
|   |                        | <del></del>                          |
|   |                        |                                      |
|   |                        |                                      |
|   |                        |                                      |
|   |                        |                                      |
| Other Medical/psychiatric health andidate                           | information that would | d be helpful to us in screening this |
|   |                        |                                      |
|   |                        |                                      |
|   |                        |                                      |
|   |                        |                                      |
|   |                        |                                      |
|   |                        |                                      |
|   |                        |                                      |
| Please attach a copy of most re-<br>eturn with this report to Brook |                        | nd other significant health data and |
|   |                        |                                      |
| Physician Signature   | Data                   |                                      |
| Physician Signature   | Date                   |                                      |
| Please Print Physician Name   |                        |                                      |