GLENMEADOW RETIREMENT COMMUNITY
REPORT OF THE EXAMINING PHYSICIAN

NOTE TO PHYSICIAN: The person named is an applicant for admission to Glenmeadow. Glenmeadow offers Independent and Assisted Living for individuals who do not have acute conditions or do not require skilled nursing care.

PLEASE READ THE ATTACHED CRITERIA FOR OCCUPANCY FOR ASSISTED/INDEPENDENT LIVING PRIOR TO COMPLETING THIS FORM. Your careful completion of EACH item will enable Glenmeadow to evaluate the ability of the applicant to live in an independent or assisted living apartment.

Also attached is an Exercise Clearance Form that must be filled out and returned.

The **date of the last doctor's appointment must be within 90 days of occupancy to Glenmeadow.**

Should you have any questions on the completion of this form please contact Torrie Dearborn at 413-567-5547.

PLEASE MAIL, FAX OR EMAIL COMPLETED FORM TO:

Glenmeadow
Attn: Torrie Dearborn
24 Tabor Crossing
Longmeadow, MA 01106

FAX 413–355-5953

EMAIL: TDEARBORN@GLENMEADOW.ORG

APPLICANT: _____

Date of Last Office Appointment:_____

Date of Birth: _____

AGE:	SEX:	HEIGHT:	WEIGHT:	BP/P:

DIAGNOSIS:

SYSTEMS	Dx	Dx	Dx	Dx	Dx	Dx
Circulatory						
Respiratory						
Nervous						
Muscular						
Skeletal						
Digestive						
Endocrine						
Reproductive						
Immune						
Excretory						
Skin						

Please explain any specific issues with any of the above diagnosis:

_____

_____

_____

_____

IMMUNIZATION HX:

	DATE	COMMENT
Influenza		
Shingles		
Pneumovax		
Tetanus		

TUBERCULOSIS SCREENING:

Mantoux test	DATE READ:	RESULTS:
Chest Xray (if needed)	DATE READ:	RESULTS:

ALLERGIES:

DRUG	
FOOD	

PHYSICAL HEALTH STATUS:

STATUS	YES	NO	Assistive Device	EXPLAIN
Auditory Impairment				
Visual Impairment				
Dentures				
Prosthesis				
Substance Abuse				
Cigarette smoker				
Able to communicate needs				

AMBULATORY HEALTH STATUS:

This person is considered:

- € Ambulatory - Physically and mentally able to exit the residence without assistance in an emergency and can ascend or descend stairs if necessary to exit the building **OR** because of physical or mental impairment, requires limited assistance , such as use of a walker, wheelchair, cane, or single verbal commands, to exit the building in an emergency.
- € Non- ambulatory – By reason of physical or mental impairment is unable to exit the building in an emergency without the assistance of another person/s.

PSYCHOSOCIAL/BEHAVIORAL HISTORY: Please check all that apply.

Anxiety		Aggressive		Disruptive		Forgetful		Noncompliant w/care	
Depression		Confused		Disoriented		Wandering Risk		Hx of Abuse	
Sleep concern problems, disturbance								Noncompliant w//meds	

Please explain specific presentation of any of the above behaviors…_____

PSYCHIATRIC DIAGNOSIS:

DX	Onset Date	Current Status	Treatment Plan/Provider

SAFETY STATUS:

Do any of the applicant's diagnoses or behaviors present a risk to the safety of self or others?

- € No
- € Yes – please explain:_____
  _____
  _____

DIETARY NEEDS:

The menu at Glenmeadow follows a 2 gm. Sodium Diet. These menu items can be chopped or pureed. Please indicate any special dietary needs of this applicant._____
_____

MEDICATIONS:

- € **Please attach a list of the applicant's current medications**.

Task	Yes	No	Explain

Applicant can safely self-administer prescriptions and over the counter drugs.			
Applicant requires assistance/supervision to self-administer prescriptions and over the counter drugs.			
Applicant is unable to self-administer prescriptions and over the counter drugs.			

MANAGEMENT OF DAILY ACTIVITIES:

Task	Yes	No	Explain
Applicant is willing and able to bathe, groom and dress self with minimal levels of assistance.			
Applicant is willing and able to ambulate or self-transport: may occasionally require limited one-person assistance.			
Applicant is willing and able to feed self.			
Applicant is willing and able to attend breakfast, lunch and dinner in the public dining room.			
Applicant is willing and able to self- manage toileting and incontinence issues or cooperate with minimal assistance.			
Applicant does not have an acute medical condition or does not require ongoing skilled nursing care, monitoring or observations.			

DNR STATUS:

It is the responsibility of the applicant's attending physician to discuss the applicant or responsible party's wishes regarding resuscitation in the event of an emergency.

If the applicant/responsible party do not wish to have resuscitation efforts made, the attending physician must write a DO NOT RESUSCITATE order and complete a Massachusetts COMFORT CARE form. Please forward this documentation if applicable.

LEVEL OF CARE:

Is this applicant appropriate for:

Independent Living _____ Assisted Living _____ Neither _____

Comment: _____

_____

Date of Physical Exam: _____

Physician's Signature:_____

Physician's Name (print):_____

Physician's Address:

_____

Physician's Phone Number:_____ Fax number: _____

Occupancy Criteria for Independent Living

Glenmeadow has sole responsibility for authorizing the admission of persons to the Apartments at Glenmeadow based on age, health, and financial stability to pay for services.

A prospective resident, or their spouse, must be at least 62 years of age.

A resident must demonstrate the ability to pay the required Entrance Fee as well as ongoing Monthly Fees.

Residents must demonstrate the ability to live independently, or provide such necessary support services, to live safely in their own Apartment. Prospective residents must have a physical form completed and submitted prior to final acceptance for tenancy. Glenmeadow reserves the right to request additional medical information.

Occupancy Criteria for Assisted Living

In compliance with the Massachusetts Regulations, Glenmeadow cannot admit persons to Assisted Living whom:

- Have acute medical conditions.
- Incontinence for which the resident cannot or will not participate or cooperate in the management of the problems.
- Have advanced stages of cognitive impairments or behavioral problems that present a danger to the resident or others.
- Are in need of skilled nursing care.
- Are immobile or require ongoing two person transfer.

All potential residents must have a designated attending physician prior to occupancy. The resident will be given a medical form by the Marketing Department, which needs to be completed by your physician and returned prior to occupancy. Activity of daily living performance criteria is used to evaluate the individual resident's level of independence and his/her level of physical and mental abilities to provide self-care. These competencies are considered when making resident placement decisions as the time of occupancy and throughout the period of residency. A physical handicap or sensory deficit is not in itself a negative criteria for occupancy. The ability to perform certain activities is the determinant of the resident's qualifications for assisted living. Glenmeadow's primary goal is to maintain residents at the most independent level at which their needs can best be met.

Criteria qualifying a resident for Assisted Living:

- Ability to bathe, groom and dress self with minimal levels of assistance.
- Ability to make personal care decisions and goals with assistance.
- Ability to ambulate or self-transport: may require limited assistance in transport outside the assisted area.
- Ability to feed self.
- Ability to attend breakfast, lunch, and dinner in the dining room.
- Requires no ongoing scheduled skilled nursing care, monitoring, or observations.
- Mentally alert to a degree that does not compromise the safety of themselves or others.
- Ability to self-medicate unless assistance is deemed necessary by the Glenmeadow health care team.
- Ability to maintain an orderly personal living space and clean personal grooming with assistance.
- Ability to leave the facility for personal needs or reasons with minimal assistance.
- Residents must have had a negative Mantoux or negative chest X-ray within six weeks of occupancy.

GLENMEADOW RETIREMENT
24 TABOR CROSSING
LONGMEADOW, MA 01106

EXERCISE CLEARANCE FORM
(page 1)

PATIENT'S INFORMED CONSENT AND AUTHORIZATION :

I, (printed name) _____, agree to voluntarily participate in a Glenmeadow exercise program and/or fitness assessment. I am aware and fully understand the exercise program may include strength training, cardiovascular, flexibility and balance exercises, all of which may increase in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body mass index, flexibility, and muscular strength and endurance.

I understand that the level of exercise that I will perform is based on my medical history, physician's recommendations, and exercise tolerance and that such information has been given to Glenmeadow. The exercise activities are designed to place a gradual increasing workload on the muscular, skeletal and cardiovascular systems. I understand that if I experience any pain, discomfort or shortness of breath, I should stop exercising immediately and notify staff.

I understand that exercise will cause certain changes to occur to my body during and after an exercise program which may include (but is not all inclusive) : abnormal blood pressure, decreased blood glucose, fainting, irregular, fast or slow heart rhythm, and in rare instances a heart attack, stroke, or cardiac arrest. I agree to participate knowing that Glenmeadow does not require its staff to be CPR certified. In the event of an emergency, the staff will assist me and call the local ambulance and emergency medical support system.

I will also promptly provide to the staff any new health information that may affect my ability to safely participate. I have been given the opportunity to ask questions related to this exercise program. I acknowledge that I have read and understand this document in its entirety.

Being aware of the potential physical risks and uncertainties of exercise, I agree to voluntarily participate in the Glenmeadow exercise program and I consent to and authorize _____ to release to Glenmeadow Retirement, any health information concerning my ability to participate in the Glenmeadow exercise program described above. I understand that this consent for release of information can be revoked by me at any time, except to the extent action has already been taken. Any personally identifiable information obtained during this exercise program will be treated as confidential and only released to my referring physician. I agree to follow any limitations set by my doctor.

Participant's Signature:	Date:
Trainer's Signature:	Date:

PHYSICIAN'S RECOMMENDATIONS:

Please complete the following recommendations for _____ to participate in a Glenmeadow exercise program by placing a checkmark before, and/or completing the statement.

PLEASE NOTE:

1. **YOUR PATIENT MUST BE ABLE TO MONITOR THEIR OWN HEALTH STATUS DURING THE EXERCISE PROGRAMS.**

2. **YOU MUST REVIEW ALL PARAMETERS WITH YOUR PATIENT.**

3. **GLENMEADOW STAFF ARE NOT REQUIRED TO BE CPR CERTIFIED. THE EMS SYSTEM WILL BE CALLED IF NEEDED.**

	A: I am not aware of any contraindications toward participation in an exercise program.
	B: I recommend that any exercise program be subject to the following specific limitations:
	C: I recommend my patient **NOT** participate in the above exercise program

Physician's Signature:	Date:
Physician's name (print):	Phone:
Address:	Fax:
City:	State/Zip: