**Admissions Department**
**18855 Victory Blvd.**
**Reseda, CA 91335**

**NOTE TO THE APPLICANT**:

Please complete the top half of this page and forward the entire report to your primary physician.

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any medical and/or psychiatric and/or social information contained in the report of the examination of:

_____
(Self or state name of person and

relationship) to the above LAJHealth.

_____
SIGNATURE

_____
ADDRESS

_____
DATE

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**NOTE TO THE PHYSICIAN:**

The person whose name appears above is an applicant for admission to theLAJHealth, a licensed Skilled Nursing facility.

We would appreciate your completing and returning this report in the enclosed envelope. We require that the applicant has seen his/her physician within the past three months of this report. It should be returned as soon as possible so that we can proceed with the application process. If you have any questions, please call us at (818) 774-3308.

Please note that your failure to provide us the information requested may delay or preclude this applicant's admission.

Thank you for your cooperation and prompt attention to this matter.

# PRE-ADMISSION MEDICAL REPORT

Applicant's Name: _____ Age _____

Date of last visit ___/___/____ Date of report ___/___/_____

Primary Physician: _____

Address: _____

_____

Phone: (___) _____ Fax: (___) _____

Last recorded blood pressure: ____/____ Date: ____/____/_____

Last recorded weight: _____ LBS. Date: ____/____/_____

**IN ADDITION TO THE INFORMATION BELOW, PLEASE ATTACH COPIES OF ANY OF THE FOLLOWING THAT IS AVAILABLE (PLEASE NOTE THAT THESE COPIES ALONE WILL NOT BE ADEQUATE; THE INFORMATION BELOW MUST ALSO BE COMPLETED):**

A. Recent hospitalization discharge summary

B. Recent complete H & P

C. Reports of diagnostic studies

1) Endoscopies, sonographies, biopsies, etc.
2) Chest x-ray
3) EKG
4) Urinalysis
5) Blood work (CBC, FBS, Electrolytes, BUN, Creatinine, Liver function, T4, TSH)

**PLEASE SEND EXTREMELY IMPORTANT**

**1. ACTIVE MEDICAL DIAGNOSES**

a._____

b._____

c._____

d._____

e._____

**2. CURRENT SYMPTOMS (If none, so state)**

_____

_____

_____

_____

**3. CURRENT MEDICATIONS AND DOSAGES**

| Routine Name | Routine Dose | PRN Name | PRN Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**LIST DRUG ALLERGIES: If NONE, so state**_____

_____

**4. PAST MEDICAL HISTORY**

a. Hospitalizations (excluding surgery) within last 5 years (including psychiatric)

| Condition | Date (mo/yr) | Hospital |
|---|---|---|
| | / | |
| | / | |
| | / | |

b. Surgical Procedures

| Surgery | Year | Hospital |
|---|---|---|
| | | |
| | | |

c. **<u>If applicant has a pacemaker, please complete the following:</u>**

Type & Manufacturer:_____

Date implanted (mo/yr) _____/_____

Surgeon: _____Hospital: _____ _

* **Other Implanted devices**:_____

Type & Manufacturer:_____

Date implanted (mo/yr) _____/_____

Surgeon: _____Hospital: _____

**PROOF OF A NEGATIVE TUBERCULOSIS STATUS IS REQUIRED <u>90 days</u> PRIOR TO ADMISSION: this means <u>written documentation of a TB skin test & Chest X-ray</u>**

d. **<u>Vaccinations</u>** (list date, if done)

| | Month/Year | | |
|---|---|---|---|
| Influenza | _____/_____ | Tetanus | _____/_____ |
| Pneumococcal | _____/_____ | Hepatitis B | _____/_____ |

**5. <u>FUNCTIONAL AND MENTAL STATUS</u>**

a. Ambulation (check which applies)

___ Independent (including with cane) and can walk more than 1-2 blocks
___ Independent (including with cane) but limited to less than 1-2 blocks
___ Uses walker
___ Not ambulatory, but can transfer independently
___ Chair-bound

b. Bathing

___ Independent
___ Needs assistance

c. Continence

___ Continent of urine and stool
___ Incontinent, urine only
___ Incontinent, stool only
___ Incontinent, urine and stool

d. Mental status

___ Confused /Disoriented
___ Inappropriate behavior
___ Aggressive behavior
___ Wandering behavior
___ Sundowning behavior
___ Able to follow instructions
___ Depressed
___ Suicidal/Self-Abuse
___ Able to communicate needs
___ At risk if allowed direct access to personal grooming and hygiene items

Comments/Describe any issues:_____
_____
_____
_____

**6. <u>Does the applicant require Skilled Nursing care?</u>**

Nursing care (needs assistance with three or more activities of daily living)

YES ____ NO ____

Comments:_____
_____
_____
_____
_____
_____
_____

Thank you,

_____, M.D. _____
Signature Date