

Congregational Home

13900 W. Burleigh Rd Brookfield, WI 53005 Ph: 262-781-0550 Fx: 262-781-0559

Admission Medical Summary for ASSISTED LIVING FACILITY (4 Pages)

Updated 4-29-21

In order to admit to Congregational Home, the following is required: This 4-page Admission Medical Summary (AMS), which includes History & Physical; Current Medications / Treatments; Orders. **AND** Original Hard Copy Prescriptions for Controlled Substances 2 - 5 must be attached.

****A Physician or Nurse Practitioner Must Sign this AMS Form Within 30 Days Prior to the planned Admission date of _____ to Congregational Home.****

****AND A separate form called "Free From Communicable Disease Statement" which includes TB and COVID must be signed within 5 days prior to admission – see attached. If patient can't make their own Medical Decisions due to Mental Incapacity, a valid Healthcare Power of Attorney and Activation Form Signed by two (2) Physicians stating patient is Mentally Incapacitated is also Required for Admission.**

Patient Name _____ DOB _____

Current Status:

Current Diagnoses / Active Problems for which patient is receiving treatment _____

Current Complaints / Symptoms _____

History:

Past Medical History / List of Diagnoses (Dementia, Diabetes, Stroke, Seizure, Cancer, etc.) _____

Past Surgical History (Type & Date) _____

Last Hospitalization: Date _____ Where _____

Why _____

Substance Use History: Smoking _____ Alcohol _____

Smokeless Tobacco _____ Vaping _____ Drugs _____

PHYSICAL EXAM / Review of Systems:

Temp _____ BP _____ Pulse _____
Resp _____ PulseOx _____

Height _____ **Weight** _____

Constitutional / General Appearance _____

Head _____

Eyes _____

Ears / Nose / Throat _____

Mouth _____

Face _____

Neck (Thyroid, Carotids) _____

Back _____

Breasts _____

Resp / Lungs _____

Cardiovascular / Heart _____

Hematologic _____

Endocrine _____

Abdomen _____

Gastrointestinal _____

Genitourinary _____

Pelvic / Rectal _____

Musculoskeletal _____

Extremities (Restrictions, Edema, etc) _____

Lymph _____

Pulses _____

Skin / Integumentary _____

Neurologic _____

Psych / Behavioral / Mental Status _____

Labs (if pertinent):

CBC _____ FBS _____

Urinalysis _____ Other _____

Imaging (if pertinent):

Note: A Chest X-Ray is required Only if patient has a History of Tuberculosis or is a known Positive Reactor, in which case the Chest X-Ray must be completed Within **30** days Prior to Admission to Congregational Home

Current Medications: (Name, Dosage, Frequency, Corresponding Diagnosis)_____

****Original Hardcopy Prescriptions for Controlled Substances Level 2 – 5 Must Come with Patient Upon Admission to Congregational Home****_____

Medication Administration:

Note: Licensed Nursing Personnel will administer medications unless patient can safely administer themselves.

_____ The patient is **NOT** capable of safely administering their own medications.

_____ The patient is capable of safely administering their own medications.

Vaccination Dates: Flu_____ Pneumovax_____ Tetanus_____ Other_____

Allergies:

Drug_____

Food_____

Diet: _____ General _____ Special, explain_____

Current Specialized Treatment:

O2_____ CPAP / BiPAP Settings_____

Wound Care, Feeding Tube, Colostomy, etc._____

Durable Medical Equipment Use:

_____ Crutches _____ Cane _____ Walker _____ Wheelchair _____ Other_____

Continence Status:

Urine_____ Stool_____

Restrictions:

Does patient have any Restrictions?_____

Are there any Activity Restrictions Inside / Outside of Facility?_____

Patient may leave Facility for Visits: _____ Alone _____ Only with Family or Friends

How Frequently should Physician Re-Check patient's Condition?_____

If Applicable, Please Initial Orders:

_____ I order Admit to **Hospice** Care at Congregational Home

_____ I order **Therapy** Eval & Treat at Congregational Home (**Can't receive Therapy if on Hospice**):

_____ Physical Therapy _____ Occupational Therapy _____ Speech Therapy

Will You Be Following the Patient's Care at Congregational Home?

_____ **NO, I will NOT be the Attending Primary Care Physician for this patient** while he/she is at Congregational Home. Please assign a facility attending primary care physician.

_____ **YES, I will be the Attending Primary Care Physician for this patient** while he/she is at Congregational Home. I will follow patient's care while at the facility, sign facility orders & take facility phone calls 24 hours a day. **In accordance with Skilled Nursing Facility regulations, I will conduct Routine Visits with the patient Every 30 Days**

_____ I will **Not** come to Congregational Home to see patient; patient will have to come to my clinic.

_____ I will come to Congregational Home to see patient.

SIGNATURE _____ **Date** _____
(Must be Signed by **PHYSICIAN**, Not PA, NP or RN)

Print Name of Physician signing this form _____

Clinic Address _____

_____ Clinic Phone# _____

If you will be Following the Patient's Care at Congregational Home, please provide Additional Physician Information:

Pager# _____ Answering Service# _____ Fax# _____

Mobile# _____ Home# _____

What Hospitals do you utilize? _____

Name of Covering Physician when you are Unavailable _____

Covering Physician Clinic Phone# _____

Pager# _____ Answering Service# _____ Fax# _____

Mobile# _____ Home# _____

****DON'T FORGET TO SIGN & DATE THE ATTACHED
"FREE FROM COMMUNICABLE DISEASE STATEMENT" FORM
WITHIN 5 DAYS PRIOR TO ADMIT TO CONGREGATIONAL HOME.
WE WILL NEED A COPY OF A COVID TEST DONE WITHIN 5 DAYS
PRIOR TO ADMISSION****

Free From Communicable Disease Statement

Updated 4-29-21

**This Form must be Signed & Dated by a Physician OR Nurse Practitioner
Within 5 days prior to admission to Congregational Home**

Return Completed Form to:

**Congregational Home
Attn: Admissions Dept
13900 W. Burleigh Rd Brookfield, WI 53005
Ph# 262-781-0550 Fx# 262-781-0559**

Patient Name _____ **D.O.B.** _____

Planned Admission Date to Congregational Home _____

**I have examined the above patient & certify that he/she is
Free From Communicable Disease, including:**

- Free from active COVID within 5 days Prior to
Admission to Congregational Home.
(attach copy of COVID test done within 5 days prior to admission)**

- Free from active TB within 30 days Prior to
Admission to Congregational Home.**

Signature _____ **Date** _____

Physician or Nurse Practitioner

Print Name & Title _____

Clinic Address _____

Clinic Phone# _____