# PHYSICIAN'S MEDICAL STATEMENT AND REPORT

On _____, I performed a physical examination of _____(must be within 30 days PRIOR to move in).

1. Current Diagnosis:
2. Physical Limitations:
3. Mental Health Limitations:
4. Treatment/Therapies (Describe medical service or nursing care needed. Attach a prescription.):
5. Supportive Services Needed:
6. Allergies:
7. Current Medications: (Current Signed Prescriptions may be attached)

**PLEASE ATTACH CURRENT PRESCRIPTIONS YOUR PATIENT IS RECEIVING SO THAT WE MAY ORDER THE CORRECT MEDICATIONS, (IF YOU R PATIENT IS NOT ABLE TO SELF-MEDICATE). PLEASE INCLUDE ANY PRN OR OTC'S THAT HE/SHE MAY TAKE AS WE ARE UNABLE TO ASSIST OR ALLOW ANY MEDICATIONS WITHOUT A WRITTEN PHYSICIAN PRESCRIPTION IN ASSISTED LIVING.**

| MEDICATION | DOSE | ROUTE | TIME TO BE GIVEN |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**DIET INSTRUCTIONS:** ___Regular Diet ___No Added Salt ___No Conc. Sweets

**STATUS OF THE FOLLOWING:**

**AMULATING**
__Independent
__Needs Supervision
__Needs Assist of 1

**BATHING**
__Independent
__Needs Supervision
__Needs Assist of 1

**DRESSING**
__Independent
__Needs Supervision
__Needs Assist of 1

**EATING**
__Independent
__Needs Supervision
__Needs Assist of 1

**GROOMING**
__Independent
__Needs Supervision
__Needs Assist of 1

**TOILETING**
__Independent
__Needs Supervision
__Needs Assist of 1

**MOBILITY**
__Independent
__Needs Supervision
__Needs Assist of 1

**MEDICATION**
__Self-Medicate
__Needs Assistance

**Doctor, please read carefully and initial each of the following only if appropriate:**

_____ The individual's behavior does not pose a danger to self or others.

_____ The individual is able to participate in supervised food preparation activities at will.

_____ The individual **DOES NOT** need 24 hour RN or LPN supervision (as in a skilled nursing home or hospital).

_____ Based on the type of care the staff of an Assisted Living may legally provide, the **individual's needs can be met in an Assisted Living Community** for adults that is not a skilled nursing home.

_____ Considering the cognitive limitations, it is my opinion that this individual requires a **secured (locked) Dementia** care unit.

_____ Individual is free from signs and symptoms of infectious skin lesions, and diseases that are capable of transmission to other residents through normal resident to resident contact.

_____ Individual is able to safely maintain and control security common of household cleaning chemicals and personal grooming supplies in own room/apartment.

_____ Individual is able to safely maintain over-the-counter medication in own room/apartment and may self-medicate OTC's at own discretion. (Order to be renewed every 6 months).

Weight: _____ Temp: _____ B/P: _____ P: _____ R: _____

Hospital Preference: _____ Nursing Home Preference: _____

Funeral Home Preference: _____

***STATE REQUIRED FOR ADMISSION TO ASSISTED LIVING COMMUNITY***
**Date 1st Step PPD Given:_____ Date 1st step PPD read:_____ Results of 1st step PPD:_____**

***2nd STEP TO BE DONE AT LUTHERAN HOMES OF SC COMMUNITY:***
**Date 2nd step PPD given_____ Date 2nd step PPD read: _____ Results of 2nd step PPD:_____**

**X-Ray results if resident known positive: _____(Attach report as necessary).**

I understand that assisted living residences are built to accordance with modern life safety and disability construction codes and fire protection requirements. In my opinion, this individual is capable of self-preservation with minimal human assistance (no more than 1 person) in an emergency involving the immediate evacuation of the facility.

**Physician's Printed Name:** _____

**Physician Signature:** _____

**Address:** _____

**Telephone:** **Fax:** **Date Signed:**

**Please return report/information to:**
**Community Name:** the Heritage at Lowman **Contact Person:** Admissions Coordinator

**Address:** 201 Fortress Dr., Chapin, SC 29036

**Phone:** 803-732-3000 **Fax:** 803-781-0292

# AUTHORIZATION OF DO NOT RESUSITATE
# RESIDENT WITH DECISION MAKING CAPACITY

I _____,have been informed of and understand the risks and benefits of Cardiopulmonary Resuscitation (CPR) and hereby request that CPR not be initiated in the event of cardiopulmonary arrest.

_____ _____
Resident's Signature Date

I, as the attending physician of this resident, have explained the consequences of an order not to resuscitate, including the potential benefits and disadvantages of such an order. Furthermore, I have determined that the resident has the ability to understand and appreciate the nature of their decision in this matter.

_____ _____
Physician's Signature Date

# AUTHORIZATION OF DO NOT RESUSCITATE
# RESIDENT WITHOUT DECISION MAKING CAPACITY

As the attending physician of, _____, I hereby authorize the entry of an order in the medical record instruction this facility not to provide Cardiopulmonary Resuscitation (CPR) or Intubation to this resident. Please check the appropriate category below:

____(a) The resident has a medical condition that can be expected to result in the imminent death of the resident.
____(b) The resident is in a non-cognitive state with no reasonable possibility of regaining cognitive functions.
____(c) The resident is a person for who Cardiopulmonary Resuscitation would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function; or would only restore cardiac and respiratory functioning for a brief period of time so that the resident will likely experience repeated need for cardiopulmonary resuscitation over a short period of time.
____(d) See Physician H&P

_____ _____
Attending Physician Signature Date

I concur with the above decision that the this Resident is a candidate for no resuscitation.

_____ _____
Concurring Physician Signature Date

As the Authorized Person, I consent to the order not to resuscitate this Resident. As I believe he/she would have wanted under the circumstances being considered.

_____ _____
Authorized Person Signature/Relationship Date

_____ _____
Witness Date

D H E C

PROMOTE PROTECT PROSPER

**Emergency Medical Services**
**Do Not Resuscitate Order**

## SOUTH CAROLINA
## EMERGENCY MEDICAL SERVICES

## RESUSCITATE

## DO NOT RESUSCITATE ORDER

### NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to

_____ that he/she has a terminal condition which has been diagnosed by me and has
(Name of Patient)

specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.

### REVOCATION PROCEDURE

**THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MULTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.**

Date _____ Patient's Signature (or Surrogate or Agent) _____

Physician's Name (Please Print) _____ Physician's Signature _____

Physician's Address _____ Physician's Telephone Number _____