***Fax copy to 912-583-2040***

Return original with resident

129 S. Railroad Ave
POB 411
Mt. Vernon, GA 30445
912-583-2020 phone
912-583-2040 fax
jimmiesue@windstream.net

Date: ____________________________

Name: ____________________________ DOB: ____________________________

Height: ____________________________ Weight: ____________________________

History: ____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

DX: ____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Please use this area as original prescription for pharmacy.

Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________
Med: ____________________ Med: ____________________

Physical or Mental Limitations: ____________________________________________

Home Heath Services /Treatment Needed: ____________________________________________
____________________________________________________________

Normal Blood Pressure Range: ______ to ______ Normal Blood sugar range: _____ to _____

Is individual free of communicable disease? ____________________________________________

Name: ____________________

**Duncan McRae House**

*Assisted Living Facility*

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**Diabetic Orders**: Can eat a regular diet unless otherwise ordered

( ) Diabetic Diet

( ) Monitor Blood Sugar: _________________

If Blood sugar rises above: ___________, instructions: ______________________________

If Blood sugar drops below: __________, instructions: ______________________________

( )Resident needs glucometer

( ) Resident needs assistance with drawing insulin only

( ) Resident needs assistance with insulin injection (ORS requires DMH staff to be trained by physician's staff prior to assisting. We will call to schedule convenient time)

( )Other: ________________________________________________________________________

**Status of the following activities of daily living:**

| | | | |
|---|---|---|---|
| Ambulating: | ___________independent | ______supervision | ______assistance |
| Bathing: | ______independent | ______supervision | ______assistance |
| Grooming: | ______independent | ______supervision | ______assistance |
| Toileting: | ______independent | ______supervision | ______assistance |
| Dressing: | ______independent | ______supervision | ______assistance |
| Transferring: | ______independent | ______supervision | ______assistance |
| Eating: | ______independent | ______supervision | ______assistance |
| Skin Integrity: | ______independent | ______supervision | ______assistance |

**Orders:**

____ Hospital bed without side rails

____ Home Health Skilled Nursing to Evaluate and treat wound care / catheter care / other_______

____ Home Health Physical therapy Evaluate and treat dx ___________________________________

____ Other: ________________________________________________________________________

*I affirm that this individual does not require continues 24 hour skilled nursing care and does not require physical or chemical restraints. I affirm that at the time of this physical this individual does not pose a danger to him/herself or others.*

**Physician signature:** _____________________ **Ga. License:** ______________ **Date:** ________

***(required)*** ***(required)***

*PPD Screening Date :* ______________________________ *Result:* ____________________

*Unable to have TB skin test due to :* __________________________ *Chest X-ray:* ____________________

*Nurse Signature:* ______________________________________ *Ga. License:* ____________________

*(required)* *(required)*

*Address:* ______________________________________________ *Phone:* ____________________