

**JEWISH HOME FOR THE AGING**

**Grancell Village  
Admissions Department  
7150 Tampa Ave.  
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 Jewish Home for the Aging.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
DATE

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**NOTE TO THE PHYSICIAN:**

The person whose name appears above is an applicant for admission to the Jewish Home for the Aging, a licensed community care 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) 774-3307.

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.

\_\_\_\_\_

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**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)**

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**3. CURRENT MEDICATIONS AND DOSAGES**

Routine			PRN	
Name	Dose	Name	Dose	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

**LIST DRUG ALLERGIES: If NONE, so state** \_\_\_\_\_

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**4. PAST MEDICAL HISTORY**

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

Condition	Date (mo/yr)	Hospital
_____	____/____	_____
_____	____/____	_____
_____	____/____	_____

b. Surgical Procedures

Surgery	Year	Hosp
_____	_____	_____
_____	_____	_____

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If applicant has a pacemaker, please complete the following:

Type & Manufacturer: \_\_\_\_\_

Date implanted (mo/yr) \_\_\_\_\_/\_\_\_\_\_

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Surgeon: \_\_\_\_\_ Hospital: \_\_\_\_\_

c.

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

d. Vaccinations (list date, if done)  
month/year

Influenza \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Tetanus \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Pneumococcal \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Hepatitis B \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**5. FUNCTIONAL AND MENTAL STATUS**

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

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d. Mental status

\_\_\_ Normal

\_\_\_ Abnormal

If abnormal, please check which applies and briefly describe below:

\_\_\_ Memory loss

\_\_\_ Other cognitive deficits

\_\_\_ Anxiety

\_\_\_ Depression

\_\_\_\_ Other (specify: \_\_\_\_\_)

**6. AT WHAT LEVEL DO YOU FEEL THIS APPLICANT IS CURRENTLY FUNCTIONING:**

- \_\_\_\_ Independent (can live alone in own apartment/home)
- \_\_\_\_ Semi-independent (needs support of residential care, i.e. meals, housekeeping)
- \_\_\_\_ Assisted Living (needs assistance with one or two activities of daily living)
- \_\_\_\_ Nursing Care (needs assistance with three or more activities of daily living)

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you,

\_\_\_\_\_, M.D.                      \_\_\_\_\_  
Signature    Date