The Payn Home

A Welcoming Home for the Independent Senior

MEDICAL EVALUATION

Name of Patient _____

Address _____

_____

M or F (circle) Date of birth _____

Date of examination _____

Does he/she have any physical of mental limitations?

_____

_____

Is he/she ambulatory without assistance? Yes _____ No _____

Please clarify _____

Is he/she incontinent? Yes _____ No _____

Please clarify _____

Does he/she require a special diet? Yes _____ No _____

Please clarify _____

Is he/she capable of administering his/her own medication? Yes _____ No _____

Please clarify _____

Is he/she addicted to alcohol, tobacco or other harmful substance? Yes _____ No _____

Please clarify _____

In your opinion is this individual capable of functioning independently in a retirement home which does not provide medical or nursing care? Yes _____ No _____

Physicians Signature _____

Physician's Name (Print) _____

Telephone (_____) _____ Date _____

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