Carmel Terrace, Inc.
933 Central Street
Framingham, MA 01701

Pre-Admission Physician's Assessment

THIS DOCUMENT IS REQUIRED *PRIOR* TO MOVE-IN TO CARMEL TERRACE.

Release Statement - To be completed by Applicant / Resident / Legal Representative:

I, _____, hereby authorize and direct my Physician,

_____, to completely and fully answer all of

the questions under "Physician's Statement" below as part of my application for residence at:

_____

_____ _____
Applicant / Resident / Legal Rep. Signature Date

Print Applicant's Name_____ SS#_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ Other:_____

Physician's Name: _____

Physician's Address: _____

City:_____ State:_____ Zip Code:_____

Telephone:_____ Fax:_____

Physician's Statement (to be completed by your physician)

Your patient has applied for residency at Carmel Terrace.
Each resident will receive a full package of services: 3 meals daily, housekeeping weekly, and personal care service, i.e., assistance with bathing, dressing, medication reminders, emergency response system and service coordination. Please know that your patient will live independently and must be self-reliant. If any of your responses need additional space, please provide the information on a separate sheet.

Per the Commonwealth of Massachusetts' Assisted Living Regulations 651 CMR 12.04 (7), this completed form must be returned or faxed back to the address listed above to complete this person's application. Thank you for your assistance.

Residence: Carmel Terrace Contact: Resident Service Coordinator
Address: 933 Central Street
City: Framingham State: MA Zip Code: 01701
Telephone: 508-788-8000 Fax: 508-626-1603

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Applicant's Name_____

Please indicate primary diagnosis: _____

Significant past medical history: _____

_____

_____

_____

Present cognitive status (including by way of example and not limitation) confusion, long and short-term memory, depression, etc.: _____

_____

Is applicant oriented to: Time:_____ Place:_____ Person:_____

Please describe any behavioral concerns, which might help us in our service planning:

_____

_____

Present psychosocial status:_____

_____

_____

Present physical health status:_____

_____

_____

Current medication(s):_____

_____

_____

Any known drug reactions:_____

_____

Is Applicant able to follow your prescribed medical regime(s): Yes_____ No_____

If no, please explain:_____

_____

_____

TB Test: Yes:_____ No:_____ Date:_____

Result:_____

Immunization Status:_____

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Applicant's Name_____

Please describe any sensory impairments:

Vision: _____

Hearing: _____

Neuropathy: _____

Blood Pressure Reading: _____

Has the Applicant suffered from any illness during the past five years that would impair his/her health physically? Yes:____ No:____ If yes, explain:_____

Cognitively? Yes:____ No:____ If yes, please explain:_____

Psychosocially? Yes ____ No ____ If yes, please explain:_____

Hospitalization(s) during the past five years? Yes:____ No:____ If yes, explain:_____

_____

_____

Is the Applicant on a special diet? Yes: ____ No:____ If yes, please explain any dietary restrictions and how we might comply:_____

_____

_____

Please indicate the Applicant's need for assistance with activities of daily living:_____

_____

_____

_____

Will the applicant need either of the following assistive devices?

Walker: Yes____ No____ Cane: Yes____ No____

Please identify any other special needs the Applicant may require, and how they might be accommodated:_____

_____

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Applicant's Name_____

Has the Applicant had any of the following diseases or disorders? **Please circle yes or no. If yes, please provide any additional information, which will aid in our service planning for the Applicant.**

Heart Disease: Yes No _____
Angina: Yes No _____
Emphysema: Yes No _____
Diabetes: Yes No _____
Cancer: Yes No _____
Urinary Problems: Yes No _____
Hernias: Yes No _____
Allergies: Yes No _____
Hemorrhages: Yes No _____
Communicable Disease: Yes No _____
Musculoskeletal impairment: Yes No _____

Infarcts: Yes No _____
Stroke: Yes No _____
Paralysis: Yes No _____
Epilepsy: Yes No _____
Hip Fracture(s) Yes No _____
Incontinence: Yes No _____
Arthritis: Yes No _____
Skin Conditions: Yes No _____
Aphasia: Yes No

Additional Comments:_____

Primary Physician's Name:_____
Primary Physician's Signature:_____
Today's Date:_____

Please return this completed form to: Amy Pessia, Admissions
Title: _____
Residence:_____
Phone:_____ Fax: 508-626-1603

Physician's Clearance Form for Health Club Participation

SUPERVISED FITNESS PROGRAMS ONLY

One of the many benefits of moving to Carmel Terrace is the availability of our Health Club, including our professionally staffed fitness programs. In order to use the Health Club and participate in the fitness programs, the resident must have his or her physician complete this Clearance Form indicating whether such resident is able to utilize the Health Club and participate in the fitness programs.

The Health Club is a physical fitness facility which contains state-of-the-art equipment to provide gentle resistance, as well as standard workout equipment such as free weights, balls, and Therabands. As part of the Health Club's offerings, residents may participate in supervised fitness programs with on-site fitness instructors.

By signing this Clearance Form, you are indicating that based on his or her medical condition, the resident may use the Health Club for supervised fitness programs. This Clearance Form is not sufficient to grant the resident access to the Health Club's open gym time.

Description of Supervised Fitness Programs.

Carmel Terrace offers various fitness programs on-site at the Health Club staffed by qualified instructors for the residents' physical conditioning, including programs targeting residents' cardiovascular, flexibility, strength, and balance. Please be assured that the activities by the fitness instructors will be designed and supervised with full respect for comfort and work tolerance.

Your cooperation in sharing any important insights or suggestions regarding the resident's physical ability on the Physician's Clearance Form would be much appreciated.

You are welcome to call the Carmel Terrace Resident Care Director, at 508-788-8000, Ext. 404, with any questions or concerns.

Health Club
Physician's Clearance Form

Please return this form to:

Carmel Terrace
933 Central Street
Framingham, MA 01701
Tel: 508-788-8000, Ext. 404
Attn: Resident Care Director

Date:_____

Patient's Name:_____DOB:_____

Date of Last Physical Examination:_____

_____ This patient may participate fully in supervised fitness programs consisting of cardiovascular, strength, and flexibility training without limitation.

_____ This patient may participate in supervised fitness programs with the following limitations and/or recommendations:

_____
_____
_____

If this patient is on any medication that may affect the heart rate or blood pressure response to exercise (elevating or suppressing), please indicate:_____

_____

I consider the above individual to be:

_____ Normal
_____ Cardiac Patient
_____ Prone to coronary heart disease

Please fill in the following information if available:

Blood Pressure:_____
Pulse:_____
Weight:_____
Other:_____

Physician's Signature:_____ Date:_____

Printed Name:_____ Address and phone #