ST. FRANCIS COUNTRY HOUSE
1412 Lansdowne Avenue
Darby, PA 19023

Phone: (610) 461-6510
Fax: (610) 461-3558

MEDICAL HISTORY & EVALUATION

Name________________________________ Age______ Sex_____

For the purpose of determining my need for skilled nursing care, I authorize the release of any medical information by the physician of St. Francis Country House.

Date:________________ Signed________________________________
(Patient or Person Acting for Patient)

I. Chief Complaints & Diagnosis:

Does patient know his/her diagnosis? YES NO

II. History			Date Onset
Illnesses			
Surgery			
Accidents			
Pacemaker	Yes No	Model: Serial#:	
Allergies			
Drug Sensitivity			
Habits	Alcohol ☐	Drugs ☐ Smoking ☐	

Family History:

III. Review of Systems WNL = normal A = abnormal - please specify & use separate sheet if necessary

Auditory	Hearing:	Tinnitus		Vertigo	
Ophthalmic	Vision:	Lacrimation		Pain	Glasses
Olfactory	Discharge	Obstruction		Epistaxis	
Respiratory System	Cough	Expectoration		Wheezing	Dyspnea
	Cyanosis	Hemoptysis		Hoarseness	Dysphagia
CVS	Chest Pain	Palpitations	Edema	Syncope	Dyspnea on Exertion
GI	Appetite:	Nausea	Vomiting	Diarrhea	Constipation
	Abdominal Pain		Jaundice	Flatulence	Hemorrhoids

GU	Frequency	Nocturia	Dysuria	Hematuria	Hesitancy	Retention	
GYN	Vaginal Discharge:		Vaginal Bleeding		Menses	Menopause	
Nervous System	Headache	Weakness	Paralysis	Seizures	Syncope	Tremors	
Musculo-Skeletal	Pain	Weakness	Deformity		Limitation of Motion		
Skin	Itching		Dryness		Burning	Urticaria	
IV. Self Care Status:	I=Independent	N=Needs Assistance		U=Unable	C=Chairridden	B=Bedridden	
Ambulatory:		Feeding:		Bathing:		Dressing:	
BLADDER CONTROL		Continent		Occ. Loss of Control		Incontinent	
BOWEL CONTROL		Continent		Occ. Loss of Control		Incontinent	
PATIENT USES:	Appliance	Catheter	Colostomy	Prosthesis	Walker	Wheelchair	
V. Communication Ability	Can: Speak ☐ Write ☐	Understands: Writing ☐		Speaking ☐		Gestures ☐	
	If not English-speaking, What Language Spoken:						
Behavior	Noisy	Belligerent	Suspicious	Withdrawn	Cooperative	Uncooperative	
Mental Status	Alert	Forgetful	Confused	Depressed	Cheerful	Agitated	Anxious
Diet	Regular	Special	Specific Type & Frequency:				

VI. Medications and/or Special Orders:______________________________

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VII. Rehabilitation Potential:______________________________

VIII. Test Results & Immunization	
	PNEUMOVAX IMMUNIZATION? No____ Yes____ If yes, when?________
	TETANUS IMMUNIZATION? No____ Yes____ If yes, when?________
	CBC-SMA7-UA (Required 7 days prior to admission) results ☐ Attached ☐ Will forward
	PPD? No____ Yes____ If yes, list date(s)/result(s): __/__/__( ) __/__/__( )
	Most recent CXR (required 60 days prior to admission) results ☐ Attached ☐ Will forward

IX. RECOMMENDATIONS:______________________________

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X. PATIENT SELF-DETERMINATION:

To your knowledge, does your patient have an Advanced Directive? Yes____ No____

Can your patient make independent decisions regarding his/her health & welfare needs? Yes____ No____

I certify that this patient's medical condition and related needs are as indicated above and that care in a skilled nursing facility is necessary.

Physician's Signature______________________________ Date:__________

Address______________________________ Tel. No.__________

Street City State Zip