MEDICAL CERTIFICATION

Twin Lakes COMMUNITY
A Division of Lutheran Retirement Ministries of Alamance County, North Carolina

This medical certification is to be completed, either typed or printed, by the family physician. Please return the completed medical certification to the attention of the Admissions Office, 3727 Wade Coble Drive, Burlington, NC 27215.

Name of Applicant _____

Address of Applicant _____

I have known the above person for _____ years and submit the following information to his/her past and current mental and physical condition:

Date of Examination: _____ Date of Birth: _____

Height: _____ Weight: _____

Temperature: _____ Blood Pressure: _____

EKG Results: _____ Pulse: _____

Albumin: _____ Sugar: _____ Microscopic: _____

Indicate if the applicant has now, or has ever had any of the following:

☐ Tuberculosis: _____ ☐ Myocardial Infarction/CHF: _____

☐ Paralysis: _____ ☐ Cancer: _____

☐ CVA: _____ ☐ Fractures: _____Which bone? _____

Is there any problem with:

☐ Sight: _____ ☐ Hearing: _____

☐ Incontinence of urine/feces: _____ ☐ Kidney/Bladder: _____

☐ Asthma: _____ ☐ Rheumatism/Arthritis: _____

☐ Skin Lesions: _____ ☐ Hemorrhages: _____

☐ Hernia: _____ ☐ Mouth (teeth, ulcers): _____

☐ Throat (swallowing): _____ ☐ Neck (glands, goiter): _____

☐ Abdomen (masses, tenderness): _____ ☐ Rectum/Pelvic: _____

☐ Circulation: _____ ☐ Epileptiform Seizures: _____

☐ Osteoporosis: _____ ☐ BPH: _____

☐ Cognitive Decline: _____ ☐ Parkinson's: _____

☐ Allergies: _____

Are the following vaccines current:

☐ Pneumococcal: _____ ☐ Date: _____

☐ Influenza: _____ ☐ Date: _____

☐ Tetanus: _____ ☐ Date: _____

☐ Hepatitis: _____ ☐ Date: _____

Two Step TB Test: Date Given: _____ Date Read: _____ Results: _____ MM: _____

Date Given: _____ Date Read: _____ Results: _____ MM: _____

Describe in detail if there are any mental deficiencies/illnesses of any kind or a history of depression or dementia: _____

_____

_____

Have there been any hospitalizations for psychiatric disorders? Yes [ ] No [ ] If so, when? For what? _____

_____

_____

Describe in detail if there is a history of the inappropriate use of drugs/alcohol: _____

_____

_____

Describe and date any surgical procedure performed (attach sheet if necessary): _____

_____

_____

Describe in detail if there is a history of diabetes: _____

_____

_____

Is there any evidence of contagious disease? Yes [ ] No [ ] If yes, describe: _____

Describe any limitation of mobility: _____

_____

Is the applicant able to administer his/her own medications? Yes [ ] No [ ] Yes, with reminders [ ]

List all medications presently prescribed: _____

_____

_____

_____

List all diet restrictions: _____

_____

Assistance is needed with: Bathing [ ] Dressing [ ] Eating [ ]

List any other pertinent diagnosis or remarks as may be considered necessary by the family physician: _____

_____

_____

This person needs 24-hour nursing care in a licensed facility: Yes [ ] No [ ]

After the Deacon Pointe nursing assessment, obtain a FL-2 from your physician. Additional medical forms may also be requested.

Signature of Physician _____ Date _____

Physician's Name and Address (please print): _____