Rapha Residential Care
"Nurturing Body, Mind and Spirit"

Dear Doctor:

Thank you in advance for your assistance in completing this History and Physical and the attached move-in orders on behalf of your patient. This information will be used to develop and deliver care individualized to your patient.

Please include in the History and Physical any history of aggressive behavior.

Rapha Residential Care provides residents with a wide variety of assistance while encouraging them to remain as independent as possible. It is important to note that we do not provide 24-hour licensed nursing care.

Thank you for your time. If you have any questions, please feel free to contact me at your convenience.

Very Truly Yours,

Paula C. Prosser
Executive Director

_____
Physician's Signature

_____
Date

3959 Fish Hatchery Road; Gaston, SC 29053 ● Main: (803) 755-6541 ● Fax: (803) 955-0453

Physician's Move-In Orders & Physical Exam

Rapha Residential Care
Nurturing Mind, Body and Spirit

Name of Resident: _____

Date of Birth: _____/_____/_____

Diagnosis: _____

_____

_____

Past Medical History: _____

_____

_____

Past Surgical History: _____

_____

_____

Specific Allergies: _____

_____

_____

General Physical Condition: _____

_____

_____

Aides/Equipment Required: _____

_____

_____

Diet (Circle One): Regular No Added Salt (NAS) Consistent Carbohydrate (CCHO)

Consistency (Circle One): Normal Chopped Mechanical Soft

Pureed Finger Foods

Portions (Circle One): Small Normal Large

Physician's Move-In Orders & Physical Exam

Physical Exam:

Height: _____ Weight: _____ Blood Pressure: _____/_____

Temperature: _____ Pulse: _____ Respirations: _____

Vision: _____ Hearing: _____

Lungs: _____ Heart: _____ Abdomen: _____

Locomotion: _____ Skin: _____

Joints and Extremities: _____

Bladder Incontinence: Yes / No Bowel Incontinence: Yes / No

If yes, can your patient manage his/her own incontinence? Yes / No

Placement: Is your patient appropriate for Assisted Living? Yes / No

Does this patient require 24 hour care by a licensed nurse? Yes / No

Is your patient capable of administering their medications? Yes / No

Does this patient have a history of aggressive behavior? Yes / No

If yes, please explain: _____

_____

_____

Is there any other information about this person that you feel we should know to help in the care of this patient? _____

_____

_____

Physician's Move-In Orders & Physical Exam

Medication Orders:

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

Medication and Dose: _____ Diagnosis:_____

At Rapha Residential Care we administer medication for our resident. If you would like your resident to have any medications, prescription or over-the-counter, available at their bedside please indicate this on the prescription.

Is there a history of drug addiction or alcohol abuse? Yes / No

Is your patient allowed to have alcohol? Yes / No

Date of physical: _____/_____/_____Physician's Signature: _____
Print Name: _____

Physician's Address: _____

_____

Physician's Phone Number: _____

Physician's Fax Number: _____

Thank you for providing the necessary information about your patient. If you have any questions, please contact Paula Prosser, Executive Director at (803) 755-6541.

RESIDENT TUBERCULOSIS TESTING RECORD

Use to document TB test performed by licensed health care provider.

Resident Name: _____ Date of Admission: _____

Physician Name: _____

1st Mantoux:

Date Given _____ Lot #: _____

Date Read: _____ Size: _____mm

Signature: _____

2nd Mantoux:

Date Given _____ Lot #: _____

Date Read: _____ Size: _____mm

Signature: _____

OR CHEST X-RAY

Date Taken: _____ Result: _____

Date Report Received: _____

If TB Skin Test is greater than 5mm, previous test results were positive, or if TB-like symptoms exist, respond to the following:

Is Resident exhibiting TB-Like symptoms? ____ Yes ____ No

Date of last chest evaluation: _____

Based on the above information, is this individual
Free of communicable disease or TB? ____ Yes ____ No

Completed by:

Signature: _____ Date: _____

Printed Name: _____ Title: _____

3959 Fish Hatchery Road; Gaston, SC 29053 ● Main: (803) 755-6541 ● Fax: (803) 955-0453