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
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? ______________________

_________________________________________________________________________________

_________________________________________________________________________________

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

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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.

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