**Welcome to Summerset Senior Living**

We are excited to welcome you to our family. We appreciate the initial trust you have placed in us and will work tirelessly to build upon it.
The transition from your current living situation requires completion and presentation of standard documents required by the State of Nevada, Department of Health and Human Services which is the licensing and regulatory division for Assisted Living Communities. These documents must be completed a minimum of 10 business days prior to the actual move in date. The attached documents include:

____ Physician documentation (5 pages), commonly referred to as the History and Physical (H&P). Most physicians require an appointment with the patient to complete these forms.
____ Physician Signed Non-Secure Letter
____ Diet Clarification
____ PRN Authorization Form
____ Physician Order for Motorized Scooter (If applicable)
____ POLST
____ Tuberculosis Testing (TB) – Please provide your patient with a Lab Order for a QuantiFERON Gold TB Test Blood Draw. If the test is positive, please provide Chest X-Ray Lab Order. PLEASE KEEP IN MIND RESULTS FROM THIS TEST TYPICALLY TAKE 3 TO 4 DAYS TO RECEIVE.

Should you require assistance in obtaining or completing any of the documents, please contact the Move In Coordinator or Community Relations Director. Kindly present completed documents via email as attachments or fax to (775) 624-6150. You can also drop off paperwork in person.

We look forward to welcoming you to your new home.

Megan Salisbury, Executive Director

Summerset Senior Living – 6215 Sharlands Avenue, Reno, NV 89523

## History & Physical/Assessment

Resident Name: _____ DOB: _____Date: _____

Physician Name: _____ Physician Phone: _____

Please Check One**:** □ **Admission** □ **Annual**

## HISTORY AND PHYSICAL

Diagnosis: _____

Height: _____ Weight: _____ Temperature: _____

Pulse: _____ Respiration: _____ Blood Pressure: _____

Ears/Hearing Hearing aids: Yes □ No □ Concerns: _____

Nose/Throat Swallowing difficulty: Yes □ No □ Concerns: _____

Eyes Cataracts: Yes □ No □ Macular Degeneration: Yes □ No □ Concerns: _____

Skin Normal Yes □ No □ Special condition:

_____

Heart Normal: Yes □ No □ Special condition: _____

Lungs Normal Yes □ No □ Oxygen required at_____ liters. Concerns: _____

Abdomen Normal Yes □ No □ Concerns: _____

Extremities Normal: Yes □ No □ Range of motion limited: Yes □ No □

Needs: (check all that apply) Walker □ Cane □ Wheelchair □ Glasses □ Dentures □

Resident is oriented to: (check all that apply) □ Person □ Place □ Time

Allergies: _____

Alcohol use: If this patient should limit alcohol consumption, please specify restrictions:

_____

This is a Nevada Licensed Assisted Living Community with 24-hour non-licensed staff.

In your professional opinion, is this patient appropriate for this model? Yes □ No □

Physician Signature: _____ Date: _____

## History & Physical/Assessment

Resident Name: _____ DOB: _____

Ambulatory Status:

Category 1 - Yes □ No □ Definition: A resident who, without assistance of any other person, **is** physically and mentally capable of moving from the room where they sleep to the other side of a smoke or fire barrier or outside the facility, whichever is nearest, in 4 minutes or less.

Category 2 - Yes □ No □ Definition: A resident who, without assistance of any other person, **is not** physically and mentally capable of moving from the room where they sleep to the other side of a smoke or fire barrier or outside the facility, whichever is nearest, in 4 minutes or less.

Please describe any Cognitive Deficits:

_____

_____

Physician Signature: _____ Date: _____

## History & Physical/Assessment: MEDICATIONS

Resident Name: _____DOB: _____

All prescribed medications and over the counter medications, vitamins, herbal supplements, nutritional drink, etc., must be listed below.

**** ALL CONTROLLED MEDICATIONS REQUIRE A HANDWRITTEN PRESCRIPTION THAT MEETS THE STATE AND FEDERAL REQUIREMENT ****

**Scheduled Medications:** (Please complete all areas requested for each medication)

| | NO RANGES | | | | | | |
|---|---|---|---|---|---|---|---|
| **Drug Name** | **Dosage to be Dispensed** | **Tabs/Caps? And How Many?** | **Frequency of Administration** | **Route to be Administered** | **Diagnosis** | **# of Meds to be Dispensed** | **# of Refills** |
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**DO NOT ATTACH MEDICATION LIST TO THIS FORM – PLEASE COMPLETE THIS FORM IN ENTIRITY**

Physician Signature: _____ Date: _____

## History & Physical/Assessment

Resident Name: _____DOB: _____

All prescribed medications and over-the-counter medications, vitamins, herbal supplements, nutritional drinks, etc., must be listed below.

**** ALL CONTROLLED MEDICATIONS REQUIRE A HANDWRITTEN PRESCRIPTION THAT MEETS THE STATE AND FEDERAL REQUIREMENT ****

### PRN MEDICATIONS

| | No RANGES | | | | | | |
|---|---|---|---|---|---|---|---|
| **Drug Name** | **Dosage to be Dispensed** | **Tabs/Caps? And How Many?** | **Frequency of Administration** | **Route to be Administered** | **Specific symptoms indication needs for use** | **Number of Meds to be Dispensed** | **Number of Refills** |
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Drug Allergies: _____

**DO NOT ATTACH A LIST TO THIS FORM – PLEASE COMPLETE THIS FORM IN ENTIRITY**

Physician Signature: _____ Date: _____

**History & Physical/Assessment**

Resident Name: _____DOB: _____

# Medication Administration:

**(please check one)**

□ Resident **is able** to self-administer all medications both prescribed and OTC. Resident is capable of storing and coordinating medications without staff assistance.

□ Resident **is NOT able** to self-administer medications, prescriptions or OTC. Staff will centrally store medications and provide assistance in administration.

Physician Signature: _____ Date: _____