Vision Form

Please have your eye doctor complete this form or send the most recent medical appointment records. This information will need to be updated annually, or as changes occur.

General Information		
Patient Name	Date of Exam	Date of Next Exam
Physician/Practice Name	Phone	
Address		
City	State	ZIP
Email	Fax	

Vision Information	
Diagnosis	
Medications	
Corrected	**Uncorrected**
OD	OD
OS	OS
OU	OU
General Eye Health	

Recommendations

☐Glasses Not Recommended ☐Glasses at All Times ☐Glasses for Distance Only ☐Glasses for Close Work Only

Other Recommendations:

Name of Physician, Please Print **Phone**

Signature & Title of Individual Performing Exam and Completing Form **Date**

Physical Form

Please have your primary care physician complete this form or send the most recent medical appointment records. This information will need to be updated annually, or as changes occur.

General Information			
Patient Name	DOB	Date of Last Exam	Date of Next Exam
Physician/Practice Name		Phone	
Address			
City		State	ZIP
Email		Fax	

Medical Information			
Blood Pressure	Height	Weight	T_____ P_____ R_____
General Appearance			
Nutritional Status			

1	**Head**	**Skin**		
2	**Eyes** Vision Screening	Right Eye	Left Eye	
	Test Used			
	Conjunctiva	Sclera	Cornea	
	Pupils	Lens	Fundi	
3	**Ears** Auditory Acuity	Right	Left	Bilateral
	Test Used	Canals	Drums	
4	**Nose**			

5	**Mouth** (gums, tongue)	6	**Teeth**
7	**Pharynx**	8	**Neck**
9	**Thyroid Gland**	10	**Lymph Nodes**
11	**Chest**	12	**Lungs**
13	**Heart**	14	**Peripheral Pulses**

Medical Information (Continued)			
15	**Abdomen**		
16	**Genitalia**		
17	**Rectal**		
18	**Extremities**		
19	**Neurological** Orientation		
	State of Consciousness		
	Cranial Nerves		
	DTR		
	Pathological Reflexes		
	Muscles Strength		
	Gait		
	Tone		
	Involuntary Movements		
20	**Joints** (contractures)		
21	**Spine** (describe any curvature)		
22	**Diet**	23	**RTC**
General Impressions			
Diagnoses			
Recommendations			

Name of Physician, Please Print **Phone**

Signature & Title of Individual Performing Exam and Completing Form **Date**

Healthcare Professionals
Medication/Treatment Order Form

A non-medical staff person may be administering medication/treatment.

General Information	
Name of Individual	Address
Telephone	Caregiver with individual
Allergies ☐ NKA	

Medications

Please list all medications/treatments that have been ordered and or discontinued. Prescriptions are good for 1year unless specified.

Mood stabilizer medications must be renewed every 90 days

Name of Medication/Treatment				
Dosage				
Hours/Times to be given				
Method to give Medication/Treatment				
Purpose of Medication/Treatment				
Stop Date				
Common Side Effects				
Condition for which Healthcare Professional Must Be Contacted				

Signature of Health Care Professional **Printed Name and Title** **Date**

Immunization & Lab Work Form

Please have your primary care physician complete this form or send the most recent medical appointment records. This information will need to be updated annually, or as changes occur.

General Information			
Patient Name		Date of Last Exam	
Physician/Practice Name		Phone	
Address			
City		State	ZIP
Email		Fax	

Immunizations			
Date of Last Tetanus/Diphtheria Booster:			
Heptavax B Vaccine	Dose 1 Date	Dose 2 Date	Dose 3 Date

Laboratory Studies			
Date of Last HGB or HCT:	Date of Last Urinalysis:	Sugar ☐Negative ☐Positive	Protein ☐Negative ☐Positive
Liver Function: *These tests should be performed annually if the individual has received behavior modifying and/or anticonvulsant medications in the last year.*			
SGOT Date:	CPK Date:	SGPT Date:	LDH Date:
Alkaline Phosphatase Date:		Anti-Convulsant Levels:	
Diet: ☐Regular ☐Special (please specify):			
Please specify any medical restrictions:			

Name of Physician, Please Print **Phone**

Signature & Title of Individual Performing Exam and Completing Form **Date**

Gynecological Exam

Please have your gynecologist complete the following form or provide a copy of your most recent appointment records. This information will need to be updated as changes occur.

General Information		
Patient Name	Date of Last Exam	Date of Next Exam
Physician/Practice Name	Phone	
Address		
City	State	ZIP
Email	Fax	

Medical Information	
Is the patient using birth control? ☐No ☐Yes, please specify:	
Has the patient had a hysterectomy? ☐No ☐Full Hysterectomy ☐Partial Hysterectomy	
Has the patient had a tubal ligation or similar procedure? ☐No ☐Yes, please specify:	
Date of Last Pap Smear:	Results:

Recommendations

Name of Physician, Please Print **Phone**

Signature & Title of Individual Performing Exam and Completing Form **Date**

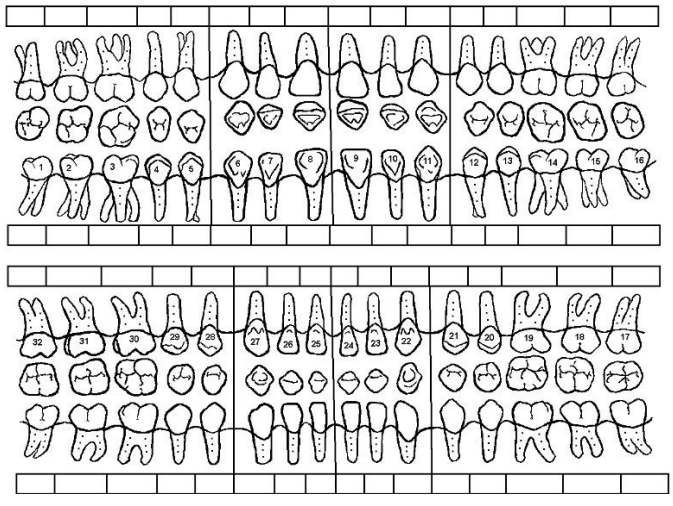
Dental Form

Please have your dentist complete the following form or send a copy of your most recent appointment records. This information is needed annually or as changes occur.

General Information		
Patient Name	Date of Last Exam	Date of Next Exam
Dentist/Practice Name	Phone	
Address		
City	State	ZIP
Email	Fax	

Dental Information		
Previous Extractions	Bleeding	Post-Operative
☐Local Anesthesia ☐General Anesthesia	☐Slight ☐Normal ☐Heavy	☐Normal Healing ☐Surgical Dressings
Osteitis		
Oral Hygiene Assessment		

Oral Examination



Gingiva	Maxilla		
	Mandible		
Growths			
Occlusion			
Ulcerations			
Other			
Dentures	Type		
Maxilla		☐Satisfactory	☐Unsatisfactory
Mandible		☐Satisfactory	☐Unsatisfactory
Service Rendered			

Recommendations

Signature & Title of Individual Performing Exam and Completing Form **Date**

Respite Inn Information

This form should only be completed if you are interested in staying at the Respite Inn.

General Information	
Name	Name of Primary Caregiver
Phone	Email

Information About My Overnight Routine
Do you typically sleep through the night? ☐Yes ☐No If no, please describe your typical sleeping patterns:
What time do you usually go to bed?
What time do you usually wake up in the morning?
What do you like to do in your free time?
Is there anything you use for comfort, or to help you sleep? (e.g. a special blanket or stuffed animal)
Is there anything that makes you feel uncomfortable or afraid? (e.g. thunder, dark, being away from family)
Is there anything else we should know about you before you stay overnight?