

Primary Physician's Report  
Mountain View Assisted Living

Resident Information

_____	_____	_____	_____	_____	_____
Last Name	First	Date of Birth	Age	Sex	Weight

MEDICATIONS PRESCRIBED BY YOU:

Name of Drug	Dosage	Instructions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER MEDICATIONS THAT YOU ARE AWARE OF:

Name of Drug	Dosage	Physician Who Prescribed it
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER HEALTH CARE PROVIDERS FROM WHOM THIS INDIVIDUAL RECEIVES CARE:

\_\_\_\_\_  
\_\_\_\_\_

RESIDENT'S DIET:

Regular    Low cal    Salt free    Soft  
Diet is recommended  Required

Frequency of visits to you:

Monthly    Quarterly  
 Other \_\_\_\_\_

MEDICAL HISTORY AND CURRENT MEDICAL PROBLEMS (attach dictated summary, if preferred)

DATE of Last TB \_\_\_\_\_  
DATE of Last Flu \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT CURRENT PHYSICAL THERAPY DOES THE RESIDENT NEED TO MAINTAIN MOBILITY:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
NAME OF PERSON PREPARING FORM  
(if other than physician)

\_\_\_\_\_  
Print physician's name

\_\_\_\_\_  
Telephone