



Franke at Seaside Active Lifestyle Community Physician's Assessment Form

Franke at Seaside is a continuing care retirement community offering a full continuum of lifestyle and health services. **This assessment is being completed for an individual who has made application to our INDEPENDENT LIVING lifestyle-based community.** This portion of our continuum offers services to individuals who are NOT in need of assistance with the activities of daily living, nursing services or supervision. Please complete the assessment with that information in mind. If you need further clarification, please feel free to call Franke Active Lifestyle Marketing Director, DeAnne Reed Vane at 843-375-5004.

TO BE COMPLETED BY YOUR PRIMARY PHYSICIAN
Return to: Franke At Seaside
Attn: DeAnne Reed Vane, Director of Marketing
1500 Franke Dr., Mount Pleasant, SC 29464
FAX: 843-375-5005

1. Personal Information

Name: _____ Date of Birth: _____

Sex: () Male () Female

Height: _____ Current Weight: _____ Usual Weight: _____

Known Allergies: _____

Date of last Comprehensive Exam*: _____

How long have you cared for applicant?: _____

2. Medical History

Primary Diagnosis: _____ Secondary: _____

Other Diagnosis: _____

Surgeries or Hospitalizations (type of procedures and dates – use additional paper if needed.):

Chronic Illnesses: (please check all that apply and give additional details pertaining to each: _____ Date of onset

- () COPD: _____/_____
- () Arthritis: _____/_____
- () Parkinson's: _____/_____
- () TIA's: _____/_____
- () Physical Limitations: _____/_____
- () Alzheimer's: _____/_____
- () Dementia: _____/_____
- () Cancer: _____/_____
- () Diabetes: _____/_____

Self-monitors BI Sugars: Yes () No ()

() Other Illness or limitations – include vision, hearing impairment, history of aggressive behavior or mental illness:

3. Most Recent Physical Exam

Vital Signs: B/P _____ Pulse _____ Resp _____ Temp _____

Mental Status:

- | | | | |
|------------------|----------------|-----------------|----------------|
| Alert & Oriented | () Yes () No | Easily Agitated | () Yes () No |
| Memory Impaired | () Yes () No | Sleep Problems | () Yes () No |
| Forgetful | () Yes () No | Depression | () Yes () No |

4. Immunizations

Date of last flu vaccine: _____

Date of last Pneumonia vaccine: _____:

5. General Mobility

Does applicant use a mobility assistance device? () Yes () No

If yes, please check all that apply:

() Cane () Walker () Scooter () Wheel Chair () Other _____

Additional comments on mobility? _____

Does applicant have a driver's license? () Yes () No

Does applicant operate a motor vehicle? () Yes () No

6. Medications

Please include a complete list of medications currently prescribed (use separate sheet if necessary.)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICIANS CERTIFICATION

I certify that I have examined _____ and the above information is accurate. In my professional opinion, this individual can safely and effectively reside in an Independent Living Community.

Physician's Signature: _____ Date: _____

Physician's Name: _____

Address: _____

Phone: _____ Fax: _____

PLEASE COMPLETE AND RETURN TO:

Franke At Seaside Active Lifestyle Community
Attention: DeAnne Reed Vane, Director of Marketing
1500 Franke Drive
Mount Pleasant, South Carolina 29464
dvane@FrankeAtSeaside.org
FAX: 843-375-5005
Phone: 843-375-5004