



Franke at Seaside Active Lifestyle Community Preliminary 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. For further clarification, please feel free to call Marketing Director, DeAnne Reed Vane at 843-375-5004.

TO BE COMPLETED BY YOUR PRIMARY CARE PHYSICIAN

Return to: Franke At Seaside

Attn: DeAnne Reed Vane, Director of Marketing

1500 Franke Dr., Mount Pleasant, SC 29464

FAX: 843-375-5005

DATE OF REPORT _____

1. Personal Information

Name: _____ Date of Birth: _____

Sex: () Male () Female

Height: _____ Current Weight: _____ Usual Weight: _____

Are you the applicant's regular physician? _____

Date of last Comprehensive Exam*: _____

How long have you cared for applicant?: _____

2. Medical History

Current Diagnoses (State fully): _____

Other Active Problems: _____

Surgeries or Hospitalizations (Procedures and dates – use additional paper if needed.):

Chronic Illnesses: (please check all that apply and provide details):

Date of onset

- () Asthma/COPD: _____/_____
- () Allergies/Sensitivities _____/_____
- () Arthritis: _____/_____
- () Parkinson's: _____/_____
- () Stroke/TIA's: _____/_____
- () Epilepsy _____/_____
- () Physical Limitations: _____/_____
- () Alzheimer's/Dementia Disorder: _____/_____
- () Alcoholism/Drug addiction: _____/_____
- () Liver disease/Hepatitis/Cirrhosis _____/_____
- () Nervous Breakdown/Psychiatric Care _____/_____
- () Cancer: _____/_____
- () High Blood Pressure _____/_____
- () Anemia _____/_____
- () Heart Disease/Heart attack _____/_____
- () Pacemaker _____/_____
- () Kidney Disease _____/_____
- () Ulcers/Stomach/Digestive problems _____/_____
- () Hernia _____/_____
- () Tuberculosis _____/_____
- () Polio _____/_____
- () Paralysis _____/_____
- () Accidents/Falls _____/_____
- () 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 _____

4. Mental Status:

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

5. Immunizations

Date of last flu vaccine: _____:

Date of last Pneumonia vaccine: _____:

Date of most recent Covid-19 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

Is applicant able to manage and administer their own medications? () Yes () No

Please include a complete list of medications currently prescribed (Attach separate medication list, 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 successfully reside in an Independent Living Retirement 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