Maple Knoll Village
New Resident Medical Assessment Form

Maple Knoll Communities, Inc. (513) 782-2717 11100 Springfield Pike Cincinnati, OH 45246
info@mkcommunities.org

Medical Form

Name: _____

Address: _____

_____
City State Zip

Telephone: _____

Email: _____

Medical Assessment Checklist

____ Submit application to Maple Knoll Village Corporate Director of Marketing

____ Complete Part I Self Report of the Medical Form

____ Schedule an appointment with your Primary Care Physician to complete Part II Physician Report

____ Notify Maple Knoll Village Corporate Director of Marketing of Medical Completion

____ Finalize Assessment Process with Maple Knoll Village Clinic for final approval scheduled by Maple Knoll Village Corporate Director of Marketing

____ Approved for Admission

NOTE TO PHYSICIAN: Your patient has applied for admission to Maple Knoll Village retirement community. All living areas of Maple Knoll Village are state licensed and require that the medical information for each resident be current. Supportive services are available in varying levels to residents as determined by location of residence in the Village. Your input will help us plan how to best meet your patient's needs. Please assist us in this process by completing **Part II** of this form.

TO THE PROSPECTIVE RESIDENT: Please complete **Part I** of the Medical Form. Please sign below to authorize the release of medical information from your physician to Maple Knoll Village. Thank you.

Patient Signature: _____ Date: _____

Medical Form Part I -- Self Report

A. Name: _____ Date of Birth: _____

B. Do you live alone? _____Yes _____No

Do you require and/ or receive any assistance with personal care? _____Yes _____No

Assistance Needed: _____

_____

If you live with your partner, do you need assistance in caring for them?_____Yes _____No

Assistance Needed: _____

_____

C. Do you currently use any home health care services? _____Yes _____ No

Name of Home Care agency is used: _____

D. Do you plan to continue with home care after moving in or Maple Knoll services?
_____ Yes _____ No Services Needed: _____

E. Do you currently use oxygen?
_____ Yes _____ No

Patient's Name: _____

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Medical Form Part II -- Physician's Report

A. Physician Name: _____ **Telephone:** _____

Office Address: _____

_____

City State Zip

Fax: _____

Patient has been seen in the last 6 months: _____Yes _____No

Physician: _____

Reason for appointment: _____

_____

B. Current Diagnosis

_____

_____

_____

C. Significant Health History

_____

_____

_____

D. Social History

_____

_____

E. List Current Medications (or attach current medication list)

Medication/Dose/Frequency	Medication/Dose/Frequency

F. Height: _____ Weight: _____ Any significant change: _____Yes _____No

	Normal	Abnormal	Abnormal Findings, Comments
Skin	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Throat	☐	☐	
Mouth	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Circulation	☐	☐	
Abdomen, Rectal	☐	☐	
Genitalia, Hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

Allergies:_____

Immunizations (tetanus, pneumovax, influenza) with dates:

_____

G. Can self-administer medications: _____Yes _____No

Unable to administer- Nurse administer_____

H. Can patient receive a TB skin test on admission? _____Yes _____No

If No, date of last chest X-ray and results: _____

Date of last chest x-ray: _____Results:_____

I. Dietary Needs

_____Regular Diet _____Other - Please specify:_____

_____No added Salt _____No concentrated sugar _____Soft

J. Sensory Deficits

_____

_____

K. Cognitive Abilities / Mental Status

_____

_____

Information is based on:

_____Evaluation _____Caregiver Report _____Patient Report

MMSE Score (If deemed necessary):_____

MOCA Score (If deemed necessary):_____

Mino-Cog Score (If deemed necessary):_____

Any history of behavioral problems:_____

Is this patient oriented to Person, Place and Time- able to recognize dangerous or unsafe situations?_____Yes _____No

Has this patient ever wandered or become lost:_____

Has the patient had any falls in the past year? _____Yes _____No

Details:_____

Patient's Name: _____

Hospitalizations/ Acute or major illness in past year:_____

_____

L. Mobility & Incontinence

Is a walking aid used? _____Yes _____No What kind:_____

Able to ambulate distances independently with or without a walking aid? _____

How far:_____

Is the patient incontinent? _____Yes _____No

Ability to manage incontinence: _____Independent _____Needs assistance

M. Skin Integrity

Are there any concerns with skin breakdown, rashes, wounds, chronic or acute?
_____ Yes _____ No Type: _____

N. Functional Assessment

Is the patient capable of self-care in the following areas?

Bathing: ____Yes ____No Toileting: ____Yes ____No

Eating: ____ Yes _____No Grooming: ____ Yes ____ No

Crafts and Hobbies: _____Yes _____No

This patient is capable of living in an Independent Apartment: _____ Yes _____ No

This patient is recommended for Assisted Living: _____ Yes _____No

Physician Signature: _____ Date: _____

Medical Form Part III—Maple Knoll Village Clinic Report

Patient's Name: _____

Date of Birth: _____

Assessment Date: _____

This patient is capable of living in an Independent Apartment: _____ Yes _____ No

If no, why? _____

_____

This patient is recommended for Assisted Living: _____ Yes _____No

If no, why? _____

_____

Additional comments or concerns: _____

_____

_____

Assessed by: _____

Medical Professional Signature: _____

Date: _____

Thank-you for your assistance. Please sign return completed forms to

Maple Knoll Village
Attn: John Ammerman
11100 Springfield Pike Attn: _____
Cincinnati, OH 45246 Phone: 513-782-2717 Fax: 513-782-4324