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

Phone_____ Email:_____

Family contact

Name: _____ Relationship: _____ Phone: _____

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: _____

Maple Knoll Village Medical Assessment Form

Medical Form Part I -- Self Report

1) Name: _____Date of Birth: _____

- 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: _____

2) Do you currently use any home health care services? ☐ Yes ☐ No
   - Name of Home Care agency is used: _____

3) Do you plan to continue with home care after moving in or Maple Knoll services? ☐ Yes ☐ No

   - If yes, please provide Agency Name: _____ Phone: _____

4) Do you currently use oxygen? ☐ Yes ☐ No
   - If yes, please provide how many L/NC_____
   - Company Name: _____Phone: _____

5) Current Pharmacy: _____ Location: _____

6) In case of an emergency, which is your choice? (These are the hospitals nearest to Maple Knoll Village)

☐ Mercy Fairfield
☐ UC West Chester
☐ Bethesda Butler

7) What is your Code Status:
- Full Code: _____
- Do Not Resuscitate Comfort Care – Arrest (DNRCCA)_____
- Do Not Resuscitate Comfort Care (DNRCC)_____

Patient's Name: _____

Maple Knoll Village Medical Assessment Form

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

_____

_____

Patient's Name: _____

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

Allergies: _____

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	☐	☐	

Patient's Name: _____

Immunizations (Covid, Pneumococcal, Influenza, Shingles) with dates:

_____

G. Can self-administer medications: ☐ Yes ☐ No *(If no, a nurse will administer medications as prescribed by MD)*

H. Can patient receive a TB skin test on admission? ☐ Yes ☐ No

If no, please provide:

Date of last chest x-ray: _____ Results:_____

I. Dietary Needs

☐ Regular ☐ No added Salt ☐ No concentrated sugar

Other – please specify: _____

J. Sensory Deficits

_____

_____

K. Cognitive Abilities / Mental Status

_____

_____

Information is based on: ☐ Evaluation ☐ Caregiver Report ☐ Patient Report

MMSE Score (If deemed necessary): _____

SLUMS (If deemed necessary): _____

Any history of behavioral problems: ☐ Yes ☐ No

If yes, explain: _____

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:_____

Patient's Name: _____

Has the patient had any falls in the past year? ☐ Yes ☐ No

Details: _____

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 walking aid? _____

How far: _____

Is the patient incontinent?

Bladder: ☐ Yes ☐ No

Bowel: ☐ 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 Dressing ☐ Yes ☐ No

Eating: ☐ Yes ☐ No Grooming: ☐ Yes ☐ No

Crafts and Hobbies: ☐ Yes ☐ No

This patient can live in an Independent Apartment: ☐ Yes ☐ No

This patient is recommended for Assisted Living: ☐ Yes ☐ No

Physician Signature: _____ **Date:** _____

Patient's Name: _____

Maple Knoll Village Medical Assessment Form

Medical Form Part III—Maple Knoll Village Clinic Report

Assessment Date: _____ Date of Birth: _____

This patient is recommended for Independent Living: ☐ Yes ☐ No

If not, why? _____

_____

This patient is recommended for Assisted Living: ☐ Yes ☐ No

If not, 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