Teresian House Medical Report

Teresian House Nursing Home – 200 Washington Avenue Extension, Albany, NY 12203
Telephone: 518-456-2000, extension 203 or 205 Fax 518-724-2796

Name: _____ Age: ____ M/S/D/W/SEP Date: _____

ADDRESS:_____

TELEPHONE: Home: _____ Work _____ Other _____

HISTORY OF PRESENT ILLNESS:

_____

_____

_____

PAST MEDICAL AND SURGICAL HISTORY

_____

_____

_____

HEPATITIS: NO _____ YES _____ TYPE_____

REVIEW OF SYSTEMS:

EYES: _____	GI _____
ENT _____	GU _____
CARDIAC _____	CNS _____
PULMONARY _____	OTHER _____

PHYSICAL EXAM: B.P. _____ HGT: _____ WGT: _____ FRAME: (S) (M) (L)

EYES: _____

ENT_____

NECK_____

CARDIAC_____

_____

RESPIRATORY_____

_____

ABDOMEN_____

_____

EXTREMITIES_____

_____

CNS_____

_____

Medical report cont'd

A current CXR Report (within 6mo.) or Mantoux Test (within 12 mo.) is required for approval.

CHEST XRAY Report (Copy) **OR** Mantoux Test Date: _____ Negative _____ * Positive _____

* If positive PPD the Chest Xray Report is required.

INFLUENZA VACCINE: Date: _____ **PNEUMOCOCCAL VACCINE: Date:** _____ **TETANUS: Date:** _____

COVID 19 VACCINE: Date:1st dose_____ 2nd Dose:_____ Booster:_____

COPIES OF LATEST LABORATORY TESTS: **CBC, URINALYSIS, COMPREHENSIVE METABOLIC PANEL, EKG**

PHYSICAL CAPACITY: GOOD _____CANE: _____WALKER:_____WHEELCHAIR _____

NEEDS ASSISTANCE WITH: BATHING _____ DRESSING _____ FEEDING _____

INCONTINENT: URINE _____ STOOL _____ SOMETIMES: _____ ALWAYS _____

MENTAL CAPACITY: ALERT _____ CONFUSED _____ ANXIETY _____ AGITATED _____

COMBATIVE _____ HALLUCINATIONS _____ DELUSIONS _____ OTHER_____

DIAGNOSES:	**MEDICATIONS:**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____

MEDICAL CARE PLAN:

DIET: _____

ALLERGIES: Food:_____ Medications: _____ Other: _____

PHYSICAL THERAPY/O.T._____

_____

TREATMENTS: _____

_____

_____

THERAPEUTIC GOALS: RESTORATIVE _____ SUPPORTIVE _____

REHABILITATIVE POTENTIAL: VERY GOOD_____ GOOD_____FAIR _____ POOR_____

_____ M.D. _____ _____

Print Name and signature Date License number

_____

Street Address City-State Zip Code

_____ _____

Telephone number M.D. Signature

SS-5 06-288 (back)