Northern Lights Community Residence
324 10th Street East
Thief River Falls, MN 56701
Phone: (218) 681-8706
Fax: (218) 681-2816

SANFORD HEALTH

Admission Physical Examination and Medical Requirements

Patient Name: _____ DOB: _____

Physician Name: _____ Clinic: _____

This report must be signed by a licensed physician, qualified nurse practitioner, or physician assistant. An electronic medical record covering the information in this form is acceptable. The following items are required prior to admission at Northern Lights Community Residence:

Physical examination and medical history was completed or is current, within the last 30 days.

☐ Yes ☐ No Date: _____ **(If No, exam must be scheduled within 5 days of admission)**

For Sanford Health Providers

Current physical examination, medical history, immunization record is available via One Chart: ☐ Yes ☐ No

For Other Providers

Copy of current physical examination, medical history, immunization record is enclosed: ☐ Yes ☐ No

Communicable Disease

This individual is currently free from communicable disease: ☐ Yes ☐ No

Current Mantoux (within the last 60 days) ☐ Yes ☐ No

(If no, Mantoux must be given within 3 days of admission or given prior to admission and read by a nurse after admission).

Date Given: _____ Location: ☐ Right Arm ☐ Left Arm _____
(Signature and Title)

Date Read: _____ Results: _____ _____
(Signature and Title)

Current Medication List and Allergies

For Sanford Health Providers

Current medication list on One Chart has been reviewed and signed by physician: ☐ Yes ☐ No

For Other Providers

List of current medications and allergies is signed by a physician and enclosed: ☐ Yes ☐ No

(The NLCR Medication Form may be completed and signed by the physician.)

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Orders

Patient Name: _____ DOB: _____

Over the Counter Medication **(See enclosed NLCR "Standing Orders for Over the Counter Medications" form for medications and protocols).**

Approved to use over the counter medications: ☐ Yes ☐ No

Exceptions to over the counter medication use: _____

_____

Diet (**Patient must be able to self manage any dietary restrictions and/or needs)**

☐Regular

☐Reduced calorie: _____ # of calories per day

☐Diabetic **(please specify)**: _____

_____

_____

_____

☐Low fat/Low cholestrol (<50 gram fat/<300 mg cholesterol)

☐No added salts (3-5 grams sodium)

Activity Level

Activity Ad Lib (no restrictions): ☐ Yes ☐ No

Exceptions/Limitations: _____

_____

_____

_____

Self Preservation Skills

In an emergency requiring evacuations from the premises (fire, gas leak, etc.), this person is capable of taking appropriate action for self preservation. ☐ Yes ☐ No

Nursing Care

Nursing services are provided a minimum of 8 hours per week to the residence. This individual is appropriate for placement in a facility providing 24-hour supervision and direction by non-nursing human service personnel. ☐ Yes ☐ No

Additional Orders **(include any orders for labs related to medications requiring periodic blood draws)**

_____

_____

_____

_____

_____

Physician Signature **Date/Time**

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Medication Form

Patient Name: _____ DOB: _____

Immunization Record	**Record date of last dose if known**	
Tetanus	Flu Vaccine	Other
Pneumonia Vaccine	Hepatitis Vaccine	Other

Allergies ☐ No Known Allergies ☐ No Known Food Allergies
Drug Allergies:
Food Allergies:
Latex: ☐Yes ☐ No ☐ Unknown Other:

Medication	Dose	Frequency	Description
lyrica			

Physician Signature **Date/Time**