Baptist Health Nursing and Rehabillitation Center
Physician's Report and Orders

Resident's Name: _____ Sex: _____ DOB: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____

Date of Physical Exam: _____
Primary Diagnosis: _____
Other Medical Diagnosis: _____
_____
_____
_____
_____
_____

Significant Medical History (include hospitalizations, surgeries):
_____
_____
_____
_____
_____
_____

Mental Status:	**Never**	**Sometimes**	**Always**
Alert			
Confused/Disoriented			
Memory Impaired			
Impaired Judgment			
Agitated			
Aggressive/Combative			
Wanders			

Is there a history of mental illness? _____ Yes ____ No
If yes, describe (include dates, hospitalizations, treatments, medications, etc.)
_____
_____
_____
_____

Allergies: _____
_____
_____

Current Medications

Name of Drug	Dosage	Frequency

Pneumovax: _____ No _____ Yes If yes, date: _____
Flu Vaccine : _____ No _____ Yes If yes, date: _____
PPD: Date Done: _____ Results: _____
If positive: chest X-ray results: _____

* Please send a copy of most recent CBC and CMP

Impairments	None	Partial	Total
Sight			
Hearing			
Speech			

_____ Wears dentures _____ Wears glasses _____ Hearing aids

MD Signature: _____
Print Name: _____
Address: _____
City: _____ State: _____ Zip: _____

If you have any questions, please contact our Admissions Office Monday - Friday at (518) 370-4700 between 9:00 am and 5:00 pm
Fax: (518) 370-0371
Thank you