KAHL HOME FOR THE AGED
6701 Jersey Ridge Road, DAVENPORT, IA 52807
PHONE (563)324-1621 FAX (563)324-1723
PRE-ADMISSION MEDICAL EVALUATION

Prospective Resident _____ Social Security Number _____ Date of Birth _____
Address _____
Present Physician _____ Physician Phone No. _____
Address _____

Present Primary Diagnosis

_____
_____
_____
Significant Past Surgeries:_____
_____
Past Psychiatric History and Hospitalizations: _____
_____
Is resident a diabetic? ____ yes ____ no If so please give the following information:
ACCU Checks ac _____ hs _____ Sliding Scale _____
Insulin Orders _____ _____
_____ _____
_____ _____
Alcohol Use/Abuse ____ yes ____ no Smoking ____ yes ____ no
Present Mental Status: ____ Always Alert ____ Alert but forgetful ____ Confused at times ____ Always confused
____Other (Describe) _____
Orientation: ____To Time ____To Place ____ To Person
Behavior: ____Cooperative ____ Combative ____Demanding ____Verbally Disruptive ____Wanders
Restraint Use: ____yes ____no (if yes describe) _____
Equipment/aids needed for ambulation: _____

Review of Systems:
Height _____ Weight _____ Pulse _____ BP _____
Appearance_____
Visual Ability_____ Eye Condition _____ Eye Glasses _____
Hearing Ability _____ Ear condition _____ Hearing Aids ___ RT ___ LT
Mouth/Throat/Nose _____
Skin Condition _____
Bowel Function/Habits _____ Incontinent ____ yes ____ no
Rectal Area _____
Urinary System _____ Incontinent ____yes ____ no
Breasts _____ Scars _____ Night Sweats ____ yes ____ no
Cough/Chest Pain _____
Lower Extremities: (edema/varicosities/ulcers) _____
Circulatory _____

Physician's Signature _____ **Date**_____

Please complete and sign all pages

Kahl Home Pre-Admission Medical Evaluation

Prospective patient: _____ Date: _____

Neuro–Muscular/Skeletal (deficits/contractures/deformities)

_____

_____

Cardio-Pulmonary _____

Nutritional Status Diet Order _____

Describe Appetite _____

Any Weight Loss _____

List Known Allergies (if any) _____

Pneumococcal Vaccine Date Given _____ If not, is it recommended? ____ yes ____ no

Tuberculosis Test Date Given _____ Tetanus Shot Date Given _____

Has Applicant been informed of all diagnosis, prognosis, and evaluations? _____yes _____no

General Prognosis _____ Rehabilitation Potential ____ poor ____ fair ____ good ____

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ACTIVITIES OF DAILY LIVING EVALUATION
(CHECK WHERE APPROPRIATE)

TASK	INDEPENDENT	1-PERSON	2-PERSON	TOTAL CARE
Ambulation				
Bed-Chair				
Climb Stairs				
Dressing				
Bathing				
Eating				
Toileting				

Describe any other limitations which prevent participating in daily activities _____

_____

___ PT ___ OT ___ ST to evaluate and treat _____ yes _____ no

O.K to administer 2-Step T.B. Test upon admission _____ yes _____ no

O.K. to Admit to Kahl Home _____ ICF _____ SNF

Physician's Signature _____

Date_____

Please complete and sign all pages

KAHL HOME

PRE-ADMISSIN MEDICAL EVALUATION

Prospective Resident_____

Current Medications including route, dose and frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PhysiciansSignature_____ **Date**_____

Revised: 9/12/2012