

KAHL HOME FOR THE AGED AND INFIRM  
6701 Jersey Ridge Rd. 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

Hospice \_\_\_ yes \_\_\_ no Hospice Provider \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

Please complete and sign all pages

