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 _____

Covid Diagnosis: _____Yes Date: _____ or _____No

Covid Test Date: _____ Result_____ ATTACH COPY of RESULTS ____Yes ____No

COVID Immunization: Received: ____Yes ____No Date(s) Received _____ 1st _____2nd

Manufacturer of Covid Immunization Received: _____

ATTACH A COPY OF THE COVID IMMUNIZATION CARD _____YES _____NO(if None)

___ 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

KAHL HOME

PRE-ADMISSION MEDICAL EVALUATION

Prospective Resident _____

Current Medications including route, does and frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Physician's Signature: _____ Date _____

Revised: 05/07/2021