Preadmission Medical Information

To the Applicant:

Blanket Authorization for Release of Medical Information

I, _____, hereby authorize my physician, _____, to release any medical information to the Willow Valley Admissions Review Committee which may be deemed necessary or helpful in determining my ability to meet the Admission requirements for Willow Valley Communities. **I understand that this form is to be completed only by my physician.**

_____ _____

Applicant's Signature **Date**

To the Physician:

Your patient is applying for the Lifecare program at Willow Valley Communities located in Lancaster, PA. The information you provide regarding your patient will be used in the Admission Review process. **Please complete this form in its entirety (front and back) and attach a copy of your patient's most recent visit summary. Please fax the completed form and latest visit summary to the Admissions Review Counselor at 717.464.6314.** We appreciate your participation in this process on behalf of your patient.

Please note: Willow Valley Communities requires your patient's last physical examination to have occurred no more than six months prior to the completion of this form.

Past Medical History

Diagnoses (Year)	Hospitalizations(Year)	Operations (Year)

Significant Family History	Significant Social History
	Exercise Type: Frequency:
	Weight: Height:
	Smokes: Y N ppd X years
	Alcohol Use: ☐ Never ☐ Occasional ☐ Regular

Current Medical Information

Current Conditions	Present	None	Date of Onset	Comments/Medications/Dosage
Alcohol/Medication Abuse	☐	☐		
Anemia/Fatigue	☐	☐		
Arthritis	☐	☐		
Bowel Problems	☐	☐		
Cancer	☐	☐		
Cardiac Conditions	☐	☐		
CVA / TIA	☐	☐		
Depression	☐	☐		
Diabetes	☐	☐		
Epilepsy	☐	☐		
Hypertension	☐	☐		
Incontinence	☐	☐		
Lung Conditions	☐	☐		
Memory Loss	☐	☐		
Neurological Disorders	☐	☐		
Progressive Debilitative Diseases	☐	☐		
Psychiatric Problems	☐	☐		
Tuberculosis	☐	☐		
Urinary Problems	☐	☐		
Other (Describe)				

Ambulation: ☐ Independent ☐ Able to walk _____ city blocks without fatigue/resting

☐ Able to climb stairs without difficulty: ☐ Yes ☐ No

☐ Needs assistance: ☐ Cane ☐ Walker ☐ Wheelchair

Allergies and Drug Sensitivities: _____

Special dietary needs: _____

Cognitive Status: ☐ Alert and Oriented ☐ Occasional Confusion ☐ Confused

Has your patient taken a Cognitive Test in the past? ☐ No ☐ Yes **If Yes, please specify the type of test, date and score:**

_____

When was your patient's most recent physical exam? _____ **(enter date)**

I have been this applicant's attending physician for _____ **years**

Printed Name of Physician: _____

Physician's Signature: _____ **Date:** _____

Physician's Office Address: _____ **Phone:** _____

Please fax a copy of the patient's most recent visit summary with this form, thank you