Please return this form to:
Westhills Village Retirement Community
255 Texas Street
Rapid City, SD 57701
Phone: 605-342-0255 • Fax: 605-394-3605

Physician Information (Confidential)

Note to physician: The person whose name appears below is applying for residency at Westhills Village Retirement Community. One of the requirements is that the person be capable of independent living. As part of this requirement, we ask you to furnish your assessment.

Patient Name _____

Date of Examination_____ Length of time under your care _____

Please describe overall physical and mental status: _____

_____

_____

List any known past/current diagnosis:

1. _____
2. _____
3. _____

Comments relating to any special health considerations with above diagnosis: _____

_____

_____

General Health: ☐Good ☐Fair ☐Poor

Functional Abilities: ☐Good ☐Fair ☐Poor

	Good	Needs Assistance	Type of Assistance
Walking	☐	☐	_____
Hearing	☐	☐	_____
Vision	☐	☐	_____
Speech	☐	☐	_____
Other	☐	☐	_____

Daily Activities:	Self	Needs Assistance	Type of Assistance
Bathing/Grooming	☐	☐	_____
Dressing	☐	☐	_____
Continence	☐	☐	_____
Other	☐	☐	_____

Cognitive Status: ☐Alert ☐ Forgetful ☐Confused

If forgetful or confused, explain: _____

_____

Evidence of Dementia ☐No ☐Yes, Explain _____

_____

History of Mental Health Problems: ☐No ☐Yes, Explain_____

Allergies: ☐ No ☐Yes, Explain _____

_____

Based on my evaluation, _____ is/is not capable of living independently in a residence at Westhills Village Retirement Community.

If not capable of living independently, he/she is capable of living in a residence with some assistance. Please describe in detail if any special conditions and types of assistance needed (needs help dressing, medication, eating, etc.): _____

_____

_____

He/She requires the use of a licensed nursing facility or assisted living facility: ☐Yes ☐No

Please list any assistance or service currently being provided in the home environment (family care assistance, home care services, etc): _____

_____

Any additional information from your records which you consider an important part of the Applicant's medical history will be helpful. _____

_____

_____

Physician's Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

_____

Signature of Physician Date

I, _____, hereby authorize my physician, _____, to complete this form and release any medical records requested by Westhills Village Retirement Community.

_____

Applicant Date

_____

Westhills Village Retirement Community Date

This patient is approved to reside at Westhills Village Retirement Community: ☐Yes ☐No

_____

Westhills Village Medical Director Date