VALLEY CARES
Medical Records Release for Assisted Living

Name of Applicant: _____ DOB: _____Date: _____

Reason for application/recent history: _____
_____

Physician name: _____ **Phone**: _____

Other providers/caregivers: _____ **Phone**: _____
Other providers/caregivers: _____ **Phone**: _____
Other providers/caregivers: _____ **Phone**: _____

Medical History/Diagnoses:

_____ _____
_____ _____
_____ _____
_____ _____

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____

COVID Immunization: _____: _____: _____: _____
Immunizations: _____
Mental Status/Behavior:

___Alert and oriented	___Short term memory loss	___Periodic confusion
___ Long term memory loss	___Withdrawn	___Enjoys social activities
___Wanders	___Sun-downing behavior	___Agitated, anxious

Please add any other information you think is important: _____
_____

Insurance Information

☐ Medicare: ___A ___B Number: _____ Effective Date: _____
☐ Medicaid: ID Number: _____
- ☐ Community Medicaid
- ☐ Long Term Care Medicaid (Choices for Care) Case worker: _____

☐ Medicare Part D (Pharmacy Insurance) _____
☐ Other Insurance:_____

By signing below, I give permission for the above individuals to share medical and functional information with West River Valley Assisted Living staff. Applicant (or representative)

***Signature*_____ *Date*_____

~OVER~

VALLEY CARES
Medical Records Release for Assisted Living

We can provide assistance with most needs. Please check appropriate level of care.

1) Dressing upper body
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

2) Dressing lower body
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

3) Grooming *(Combing your hair, putting on makeup or shaving, and brushing teeth)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

4) Bathing *(Includes running water, getting in and out of tub/shower, washing all body parts)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

5) Eating *(includes cutting your own food, feeding self)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

6) Bed Mobility (*How well can you manage sitting up or moving around in bed?)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

7) Transferring (*How well can you move in and out of a bed or chair?)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

8) Toileting (*Includes adjusting your clothing, getting on and off toilet, and cleaning yourself)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent
If incontinent, how much help do you need to manage with changing pads, cleaning yourself, etc.
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

9) Climbing Stairs (*One flight of stairs)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent

10) Specify assistive device needed for mobility: _____
Mobility (*How well can you move *<u>within</u> the home, not including stairs?)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent
Mobility (*How well do you manage about 100 yards or a block *<u>outside</u> the home?)*
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent
11) Managing medications:
☐Independent ☐ Supervision/Cueing ☐Some Assistance ☐Dependent
Please explain: _____

Please note that all information in this application is kept completely confidential and is used only by our staff for the purpose of assessing the appropriateness of your moving to Valley Cares.

If you have any questions, please contact the Facility Nurse at 802-365-7190.