FOX MEADOW RETIRMENT HOME, LLC
1151 SUMMER STREET
BRISTOL, NEW HAMPSHIRE 03222
PHONE (603) 744-5020 FAX (603) 744-9193

Resident Pre-Admission or Annual Evaluation

(To be completed by licensed Physician)

Resident Name: _____ DOB_____

Vital Signs: B/P: _____ Temp: _____ Pulse: _____ Weight: _____

Allergies: _____

Medical Diagnosis (if any): _____

_____

Special Dietary Needs (if any): _____

_____

All Current Prescriptions/Medications and OTC Medications: (Per state regulations any PRN medication must include indications for use and any special precautions, limitations and common side effects to use the medication that would require notification of the physician, including the max allowed dose within a 24 hour period. Unless noted otherwise, the warning label on the bottle will be followed):

_____

_____

_____

_____

_____

If a signed medication list will be attached in lieu of listing on this form, please indicate the number of pages and sign the list and you agree unless noted otherwise, the warning label on the bottle will be followed for all PRN and OTC medications. **List Attached:** yes or no (please circle) **No of pages:** _____

Medical Findings (absence of communicable disease, etc): _____

Medical History: _____

_____

_____

Is resident a known sex offender: yes or no (please circle) If yes please attach explanation:

FOX MEADOW RETIRMENT HOME, LLC
1151 SUMMER STREET
BRISTOL, NEW HAMPSHIRE 03222
PHONE (603) 744-5020 FAX (603) 744-9193

Resident Pre-Admission or Annual Evaluation

(To be completed by licensed Physician)

Resident Name: _____ DOB_____

Self Care Status:	**Independent**	**With Supervision**	**With Assistance**	**Resistant to**
Personal Hygiene	_____	_____	_____	_____
Bathing	_____	_____	_____	_____
Dressing	_____	_____	_____	_____
Eating	_____	_____	_____	_____
Walking	_____	_____	_____	_____
Climbing Stairs	_____	_____	_____	_____
Transfers	_____	_____	_____	_____

Continent of Bladder: yes or no (please circle) Continent of bowels: yes or no (please circle)

Over the Counter (OTC) Medications: (The following OTC medications and/or generic brands are authorized to be taken as needed according to label on bottle unless specified with different instructions below – cross out medications not authorized or add as necessary):

Aspirin Ibuprofen Acetaminophen Multivitamin Calcium/Vitamin D Vitamin C

Tums Metamucil Docusate Sodium Cough Syrup Benadryl Cough Drops Pepto Bismol

Last Known Immunization for Influenza: _____ For Pneumucoccal Disease: _____

Vaccine for COVID: _____ Date: _____

Test results for COVID: _____ Date: _____

Note to Physician: Space below is for you to provide additional information if necessary:

_____

_____

_____ _____ _____

Physician Signature Date Physician printed name