HERITAGE
AT FRAMINGHAM

747 Water Street ■ Framingham, MA 01701 ■ *phone* 508-665-5300 ■ *fax* 508-788-6601 ■ www.heritageassistedliving.org

MEDICAL FORM FOR HERITAGE

FAMILY FILLS OUT THIS SECTION

I, _____, hereby authorize Physician
(Prospective Resident or family representative)

_____
(Print Physician name)

to completely and fully answer all questions under the Physician's statement as part of the application for residence at Heritage at Framingham, 747 Water Street, Framingham, MA 01701.

_____ _____
Applicant/representative's signature Date

Applicant name _____ Social Security # _____

Address _____ Phone _____

City/State/Zip _____ Birth date _____

PHYSICIAN'S STATEMENT

PHYSICIAN FILLS OUT THIS SECTION

State Regulations Require for All Assisted Living Applicants

Primary diagnosis _____

Additional diagnoses _____

Past medical history _____

Present health status _____

Present mental status (e.g., memory, depression, etc.) _____

_____

Orientation to:

Time ☐ Yes ☐ No Place ☐ Yes ☐ No Person ☐ Yes ☐ No

Behavioral concerns _____

_____

Current medications/dosages _____

_____

_____

_____

Allergies _____

Able to follow prescribed medical regime? ☐ Yes ☐ No

Sensory impairments:

Vision ☐ Yes ☐ No Hearing ☐ Yes ☐ No

Blood pressure reading _____

Illnesses; past 5 years impairing physical or mental health _____

_____

Hospitalizations, past 5 years _____

_____

Special diet? ☐ Yes ☐ No

Dietary restrictions _____

_____

_____

Assistance with activities of daily living _____

_____

Continent of:

Bladder ☐ Yes ☐ No Bowel ☐ Yes ☐ No

Durable medical equipment:

Walker ☐ Yes ☐ No Cane ☐ Yes ☐ No Wheelchair ☐ Yes ☐ No Other _____

Other special needs/additional comments _____

_____

_____

_____

_____

_____

Physician's signature _____

Physician's name printed _____

City/State/Zip _____ Phone _____

Fax completed form to: 508-788-6601 or email to: lcanavan@heritageassistedliving.org