

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___ Long term memory loss ___ Withdrawn ___ Enjoys social activities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 _____

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 *within the home, not including stairs?*)
Independent Supervision/Cueing Some Assistance Dependent
Mobility (*How well do you manage about 100 yards or a block *outside 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, Eileen Ogden RN, Director of Nursing at 802-365-7190 at Ext 104