



Northern Lights Community Residence
 324 10th Street East
 Thief River Falls, MN 56701
 Phone: (218) 681-8706
 Fax: (218) 681-2816

Admission Physical Examination and Medical Requirements

Patient Name: _____ DOB: _____
 Physician Name: _____ Clinic: _____

This report must be signed by a licensed physician, qualified nurse practitioner, or physician assistant. An electronic medical record covering the information in this form is acceptable. The following items are required prior to admission at Northern Lights Community Residence:

Physical examination and medical history was completed or is current, within the last 30 days.
 Yes No Date: _____ (If No, exam must be scheduled within 5 days of admission)

For Sanford Health Providers

Current physical examination, medical history, immunization record is available via One Chart: Yes No

For Other Providers

Copy of current physical examination, medical history, immunization record is enclosed: Yes No

Communicable Disease

This individual is currently free from communicable disease: Yes No

Current Mantoux (within the last 60 days) Yes No

(If no, Mantoux must be given within 3 days of admission or given prior to admission and read by a nurse after admission).

Date Given: _____ Location: Right Arm Left Arm _____
 (Signature and Title)

Date Read: _____ Results: _____
 (Signature and Title)

Current Medication List and Allergies

For Sanford Health Providers

Current medication list on One Chart has been reviewed and signed by physician: Yes No

For Other Providers

List of current medications and allergies is signed by a physician and enclosed: Yes No

(The NLCR Medication Form may be completed and signed by the physician.)



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Admission Physical Examination and Medical Requirements Orders

Patient Name: _____ DOB: _____

Over the Counter Medication (See enclosed NLCR "Standing Orders for Over the Counter Medications" form for medications and protocols).

Approved to use over the counter medications: Yes No

Exceptions to over the counter medication use: _____

Diet (Patient must be able to self manage any dietary restrictions and/or needs)

Regular

Reduced calorie: _____ # of calories per day

Diabetic (please specify): _____

Low fat/Low cholestrol (<50 gram fat/<300 mg cholesterol)

No added salts (3-5 grams sodium)

Activity Level

Activity Ad Lib (no restrictions): Yes No

Exceptions/Limitations: _____

Self Preservation Skills

In an emergency requiring evacuations from the premises (fire, gas leak, etc.), this person is capable of taking appropriate action for self preservation. Yes No

Nursing Care

Nursing services are provided a minimum of 8 hours per week to the residence. This individual is appropriate for placement in a facility providing 24-hour supervision and direction by non-nursing human service personnel. Yes No

Additional Orders (include any orders for labs related to medications requiring periodic blood draws)

Physician Signature

Date/Time



