



PHYSICIAN'S STATEMENT

Woburn Marlborough

I, _____, hereby authorize and request my physician, _____, to release and furnish all information regarding my medical history and current medical status to New Horizons, in conjunction with my application for residency at that facility. I further authorize any other health care providers and facilities to release future health care records and related information to New Horizons' Executive Director.

Date

Applicant (or Authorized Representative)

Please print clearly to expedite this application process.

Applicant's name: _____ Date of birth: _____

Note to physician: Your patient has applied for entrance to our New Horizons senior community, which offers a continuum of programs, including:

- (1)* Apartment-style independent living - includes one meal daily, with an option for another meal, at additional cost; living accommodation is a typical apartment with full kitchen in multi-story buildings.
(2) Independent living with hospitality services - includes three meals daily, plus light housekeeping and linen laundering; suite living accommodation includes kitchenette.
(3) Assisted living - includes same services as (2), plus access to home health aides for assistance with activities of daily living at additional cost, e.g. bathing, dressing, escorts to meals and activities, etc.
(4) Alzheimer care wing - a secure facility, independently operated, offering the same services as (2), plus special care services tailored to individuals living with Alzheimer's or related dementias.
(5)* Mental health enhanced care unit - a secure facility, independently operated, offering the same services as (2), plus special care services tailored to individuals suffering from conditions such as acute anxiety disorder or depression.

* Programs (1) and (5) are available at the Marlborough facility only.

Neither facility (Woburn or Marlborough) provides long-term nursing care or skilled nursing services. Please keep these factors in mind as you evaluate your patient's present physical and mental health. If any answer herein requires additional space, please feel free to supplement this form.

Once completed, this form must be received by New Horizons before any action can be taken on the application. Thank you in advance for your vital, timely assistance. Please mail or fax this form to whichever facility is indicated above:

New Horizons at Choate, LLC ■ 21 Warren Avenue ■ Woburn, MA 01801 ■ fax: 781-938-8355

New Horizons at Marlborough, LLC ■ 400 Hemenway Street ■ Marlborough, MA 01752 ■ fax: 508-460-7682

Present health status: _____

Allergies: _____

Special diet: _____

Current medications: _____

Medical history: _____

Recent hospitalizations (last five years) and diagnoses: _____

Is Applicant able to independently and accurately follow your prescribed medical regime? _____

Comments: _____

Is Applicant able to independently perform the activities of daily living? _____

Comments/limitations: _____

Does Applicant use a walker? _____ Cane? _____ Wheelchair? _____

If wheelchair is used, can Applicant transfer on his/her own? _____

Does Applicant have difficulty with stairs? _____

Is Applicant oriented as to: Time? _____ Place? _____ Person? _____

Does Applicant have appropriate behavior patterns? _____

Please answer yes or no if Applicant has or has had a history of any of the following diseases or disorders.

Angina: _____	Asthma: _____	Sensory deficits: _____	Epilepsy/seizures: _____
Arrhythmia: _____	COPD: _____	Visual: _____	Parkinson's: _____
CHF: _____	Arthritis: _____	Auditory: _____	Dementia: _____
Hypertension: _____	Osteoporosis: _____	Speech: _____	Anxiety: _____
MI: _____	Alcohol abuse: _____	Cancer: _____	Depression: _____
CVA: _____	Drug abuse: _____	Eating disorder: _____	Decubiti/skin cond.: _____
Emphysema: _____	Incontinence: _____	Diabetes: _____	Communicable disease: _____

If you answered yes to any of the above, please supply supplemental information including dates and prognosis:

Will you continue to follow Applicant after his/her move to New Horizons? _____

General comments: _____

Immunization (dates): Tetanus: _____ Influenza: _____ Pneumococcal: _____

Per CDC guidelines, all applicants must have a tuberculosis screening within 90 days prior to move-in:

Mantoux Test Results: Step 1 Negative _____ mm Positive _____ mm Date _____
Step 2 Negative _____ mm Positive _____ mm Date _____

X-ray results: Date _____
 Normal Abnormal/TB No TB Infection
 Non-active TB Infection TB Suspect

I recommend this applicant for residence at New Horizons:

- (1) Apartment-style independent living (*Marlborough only*)
- (2) Independent living with hospitality services
- (3) Assisted living
- (4) Alzheimer care wing
- (5) Mental health enhanced care unit (*Marlborough only*)

Physician's name: _____ Signature: _____ Date: _____

Address: _____ Phone (____) _____