



19116 Colonnade Way
Surprise, AZ 85374
(623) 236-3770

PHYSICIANS CONFIDENTIAL REPORT

Sale

To be completed, signed and sent to the office of the Marketing Director at **FAX: 623-236-3779**

I am applying for residency at The Colonnade, and hereby authorize the release of my medical records to The Colonnade for review.

Signature _____ Date _____

Name of Applicant: _____ Age: _____

Address: Street: _____ City: _____ State: _____ Zip: _____

How long have you known the applicant: _____

Date of birth: Month: _____ Day: _____ Year: _____

Height: _____ Weight: _____ General Physical Condition: _____

Current illness or disability: _____

Chronic illness or disability: _____

Medication or treatment patient is now receiving: _____

Prognosis of illness or disability: _____

Prostheses now used by patient (including dentures, glasses, hearing aids, trusses, braces, artificial limbs, walking aids, etc.): _____

PAST MEDICAL HISTORY

Diseases (including allergies, nervous and mental disorders): _____

Accidents (type and date of each): _____

Operations (type and date of each): _____

Physical Examination at Time of Application:

Is there any evidence of dementia: _____

Is there any evidence of need of immediate nursing care: _____

General mental condition and emotional status: _____

Temperature: _____ Pulse: _____ Respiration: _____

Blood Pressure: Systolic: _____ Diastolic: _____

Systemic Review: _____

Pg.2 – Continued
Name of Applicant _____

Head (including EENT): _____
Neck: _____
Chest: _____
Cardiovascular: _____
Abdomen: _____
Genitourinary: _____
Skin: _____
Bones and Joints: _____
Glandular: _____
Neuromuscular: _____
Any indication of malignant or contagious disease: _____

Recent laboratory, X-ray, Electrocardiographic or similar reports: _____

TB Skin Test: _____
Had Flu Vaccine: _____
Do you know of any unlisted physical disabilities: _____

Elaboration of history and findings when indicated: _____

To what extent does the applicant use alcoholic beverages, mood altering or nonprescription medications: _____

Has the patient ever been hospitalized or institutionalized for drug or alcohol rehabilitation: _____

Do you know of any reason why the applicant would not qualify as a congenial participant in the normal activities of family life at The Colonnade : _____

Can this applicant live independently? _____

Date of examination: _____ Signature of physician: _____

Print name of physician: _____ Phone #: () _____

FAX #: () _____

Address: Street: _____ City: _____ State: _____ Zip: _____

Thank you for your prompt response.
Upon completion of this report, please FAX to (623) 236-3779
Forward the original signed report to: Marketing Director, The Colonnade,
19116 Colonnade Way, Surprise, AZ 85374