



A Sun Health Senior Living Community

14515 W. Granite Valley Drive
Sun City West, AZ 85375
(623) 975-8014
FAX (623) 546-3752

PHYSICIANS CONFIDENTIAL REPORT

To be completed, signed and sent to the office of the
Director of Resident and Health Services. FAX # (623) 546-3752

I am applying for residency at **Grandview Terrace**, and hereby authorize the release of my medical records to **Grandview Terrace** for review.

Signature _____ Date

PLEASE NOTE: All questions in BOLD print must be answered by the physician before approval will be granted.

Name of Applicant:

Age:

Address:

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?



Physical Examination at Time of Application: (CONTINUED)

General mental condition and emotional status:

Temperature:

Pulse:

Respiration:

Blood Pressure:

Systolic:

Diastolic:

Systemic Review:

Head (including EENT):

Neck:

Chest:

Cardiovascular:

Abdomen:

Genitourinary:

Skin:

Bones and Joints:

Glandular:

Neuromuscular:

Any indication of malignant or contagious disease?



Physical Examination at Time of Application: (CONTINUED)

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 **Grandview Terrace**?



Physical Examination at Time of Application: (CONTINUED)

Can this applicant live independently?



Date of Examination:

Signature of Physician: _____

Name of Physician:

Phone #:

FAX #:

Address:

City:

State:

Zip:

Thank you for your prompt response.

Upon completion of this report, please FAX to (623) 546-3752.

Please forward the original, signed report to:
Director of Resident and Health Services at **Grandview Terrace**
14515 W. Granite Valley Drive
Sun City West, AZ 85375