PAYN
RESIDENCE

Medical Evaluation Form

Carefree, affordable, independent senior living

Name of Patient _____ Date of Examination _____

Address _____

Male or Female (Circle) Date of Birth _____

Does he/she have any physical or mental limitations? Yes ____ No ____ (If yes, please explain) _____

_____

Is he/she ambulatory without assistance? Yes ____ No ____ (If no, please clarify) _____

_____

Is he/she incontinent? Yes ____ No ____ If yes, can this individual care for themselves? Yes ____ No ____

Does he/she require a special diet? Yes ____ No ____ (If yes, please clarify) _____

_____

Is he/she capable of administering his/her own medications? Yes ____ No ____ (If no, please clarify) _____

_____

Is he/she addicted to alcohol, tobacco or other harmful substance(s)? Yes ____ No ____ (If yes, please clarify) _____

_____

In your opinion is this individual capable of functioning independently in a retirement home which does not provide medical or nursing care?

Yes ___ No ___

Physicians Signature _____ Physicians Name (Print) _____

Telephone ( ) _____ Today's Date _____

12 Coleman Street, Chatham, NY 12037 (518) 392-4971
info@paynhome.org www.paynhome.org