THE VIRGINIA HOME
1101 Hampton Street
Richmond, Virginia 23220
Phone: 804-359-4093 FAX: 804-359-8961

Admission Medical History and Physical Form

TO: PHYSICIAN COMPLETING THIS MEDICAL INFORMATION

You are being presented papers for completion in reference to application for admission to The Virginia Home by a patient of yours. As you probably know, *The Virginia Home* is a long-term care nursing facility specializing in the needs of the physically disabled. Applicants are accepted for admission with the belief that they are able to benefit from our unique service and are able to participate in, and profit from, community living. It is felt unwise to accept those who do not meet these criteria. I hope in completing the form you will take into account these limitations. Although our staff will make personal contact with each person prior to actual admission, in order for us to do our most effective work with these people, we need certain specific information from the attending or referring physician.

- *A statement of history and a brief resume of physical defects which will be used in determining eligibility for admission to The Virginia Home's waiting list.*
- *A statement of the applicant's need for nursing home care.*
- *Due to the fact there is a three to five year waiting period for admission to The Virginia Home laboratory work, tuberculosis testing, etc. will not be done until notification of admission.*

Since our waiting list is quite long, and situations do change during the intervening time between application and final admission, it may be necessary to request updates or additional information about the applicant. By the same token, we have minimized the information required to conserve your time and effort. Upon actual admission to The Virginia Home, the resident will have a complete history and physical examination performed by a staff physician, who will then have the prerogative to order those tests which he feels are necessary for further evaluation or care of the applicant.

Thankfully, our residents are with us for a long time. Each is not only affected and influenced by The Home and staff but in turn influences our staff and the other occupants of The Home very directly. It is for these reasons that we investigate so thoroughly prior to acceptance.

Best Wishes,
The Admission Committee

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This Form Must Be Completed by the Referring Physician

Patient's Name : _____
Last *Middle* *First* *Suffix*

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

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Today's Date: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Occupation: _____

Referring Physician: _____
Last *Middle* *First* *Suffix*

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

How long have you been attending to the patient: _____

HISTORY and PHYSICAL EXAM

History

(Please write in narrative from the beginning of patient's disabling illness to present)

1. Chief Complaint: _____
2. History of Present Illness: _____

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3. Brief Description of patient's personality, behavior, mentality, ability to communicate and emotional stability:

_____
_____
_____
_____
_____
_____

4. Systematic Review:

a. Skin: _____
b. Head: _____
c. Eyes: _____
d. Ears: _____
e. Nose: _____
f. Throat: _____
g. Teeth: _____
h. Neck: _____
i. Breasts: _____
j. Last Chest X-Ray: _____
k. Respiratory: _____
l. Cardiovascular: _____
m. Gastrointestinal: _____
n. Genitourinary: _____
o. Gynecological: _____
p. Musculoskeletal: _____
q. Neurological: _____
r. Psychiatric – please indicate past treatment: _____
s. Allergy or Drug Reactions: _____

5. Past Medical History:

a. Illnesses: _____
b. Operations: _____
c. Injuries: _____
d. Please indicate dates, duration, etc. _____
_____
_____

6. Family History (If dead, age and cause of death)

Father: _____
Mother: _____
Brothers: _____
Sisters: _____

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Familial Diseases: Cancer, Tuberculosis, etc. _____
_____
_____

Mental Illnesses: ☐ Yes ☐ No Mental Hospitalization: ☐ Yes ☐ No

7. Social History:

Place of Birth: _____
Extent of Education: _____
Age at Marriage: _____
Use of Tobacco: _____
Use of Alcohol: _____
Type of Occupation: _____
Hobbies or Interest: _____
Dependencies: □None □ ETOH □ Rx Drug □ Illicit Drug □ Other: _____

8. Medications: Allergies to medications:
   - ❑ Yes (Please list allergies):_____
   - ❑ No

Please List present Medications and Dosage: _____
_____
_____
_____
_____

Physical Examination

Vital Signs: Blood Pressure: _____/_____ Heart Rate: _____/beats per minute
systolic diastolic

Height: _____ Weight: _____
Feet Inches pounds

General Appearance: □ Good □ Fair □ Poor

Mentality: □ Alert □ Dull □ Insane Mobility: □ Ambulatory □ Bed □ Chair

Bowel & Bladder: □ Continent □ Incontinent Dentures: □ Yes □ No

Vision: Optician Name and Rx: _____
Right Eye - 20/____ Left Eye – 20/____ With Glasses: Right Eye-20/____ Left Eye – 20/____

Ears: Right_____ Left_____ Hearing Aid: □Yes □No

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Nose _____ Throat _____ Teeth _____ Thyroid_____

Lungs _____ Breasts _____

Heart Size_____ Murmurs_____ Rhythm _____

Abdomen: Organs Felt Enlarged _____ Tenderness _____

Spasm _____ Hernia _____ Genitalia_____ Pelvic_____

Rectal _____ Arms & Hands _____ Legs & Feet_____

Varicose Veins _____ Spine _____ Reflexes _____

In your professional opinion, will the patient adjust to Institutional living? □ Yes □ No
In your professional opinion, does the patient need long-term nursing home care? □ Yes □ No

Laboratory Work & X-Ray of Chest:
Due to the fact that there is a three to five year waiting period for admission to The Virginia Home, laboratory work, tuberculosis testing, chest x-ray etc. will ***not*** be completed until notification of admission.

_____
Physician's Signature

_____
Physician's Name Printed

Please Return Completed History & Physical To:

Director of Admissions
THE VIRGINIA HOME
1101 Hampton Street
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