



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. 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 senior community. From the five programs listed below, please choose the program best suited to your patient.

PLEASE INDICATE YOUR RECOMMENDATION BY CHECKING THE APPROPRIATE BOX:

The following two programs are offered at New Horizons Woburn and Marlborough:

- ( ) Independent living with hospitality services - includes three meals daily, plus light housekeeping and linen laundering; suite living accommodation includes kitchenette.
( ) Assisted living - includes same services as above, 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.

The next three programs are offered at New Horizons Marlborough only:

- ( ) 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.
( ) Alzheimer care wing - a secure facility - includes three meals daily, plus light housekeeping and linen laundering, plus special care services tailored to individuals living with Alzheimer's or related dementias.
( ) Mental health enhanced care unit - a secure facility, independently operated - includes three meals daily, plus light housekeeping and linen laundering, plus special care services tailored to individuals suffering from conditions such as acute anxiety disorder or depression.

Neither community (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 with progress notes or attachments.

Once completed, please mail or fax this two-sided form to whichever community is indicated above. Thank you in advance for your vital, timely assistance.

New Horizons at Choate, LLC 21 Warren Avenue Woburn, MA 01801 fax: 781-938-8355
New Horizons at Marlborough, LLC 400 Hemenway St. Marlborough, MA 01752 fax: 508-573-1144

Present health status: \_\_\_\_\_

Current medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Special diet: \_\_\_\_\_

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** 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: \_\_\_\_\_

COVID \_\_\_\_\_ COVID Booster \_\_\_\_\_

Physician's Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_