Dear Colleague,

has applied for admission to the New Jersey Eastern Star Home, Inc. It is important that he/she receive a complete medical examination within three (3) months of his/her admission date. We also require a past medical history that is as complete as possible. Please obtain a CBC, CMP, U/A, Chest X-ray and two step PPD in conjunction with the above requested medical examination. Please send results with the enclosed physical examination form. Additionally, please note the last DT, Flu Shot and Pneumonia Immunization. If they are not up to date please administer them. Your examination and evaluation of this applicant will be carefully reviewed by our medical staff. Your comments concerning the degree of independence, ambulation, and ability to adjust to congregate living will be most helpful.

Attached is a form titled, “Pre-Admission Screening and Resident Review”. This document is required for admission into the facility. It is a requirement of the New Jersey Department of Human Services. Please read each question carefully. We do not want to inconvenience you by having to request that you do the form a second time because of errors. If you have any questions, please do not hesitate to call the Admissions Department at 908-722-4140 and ask for Ext. 3589.

Your cooperation and promptness in returning the medical examination form with the pertinent lab studies attached is greatly appreciated. Thank you for your assistance.

Sincerely,

Richard Corson, M.D.
Medical Director

Enc.

PHYSICIAN'S REPORT

DOCTOR: Please mail or Fax this report to:

Fax Number: (908) 722-9566

Director of Admissions &
Business Development
New Jersey Eastern Star Home, Inc.
111 Finderne Avenue
Bridgewater, NJ 08807

Name: _____ Birth Date: _____

Address_____

_____

1. Past & Present Dx. with current corresponding treatment:_____

_____

2. Medications: *(Please attach a typed copy. A handwritten list of medications cannot be accepted.)*
3. Surgical History: _____
4. Review of Systems:
   a. HEENT (Vision & Hearing loss?)
   b. Cardio-Respiratory: _____
   c. Gastrointestinal: _____
   d. Genitourinary: _____
   e. Gynecological:_____
   f. Muscle Skeletal:_____
   g. Hematological:_____
   h. Neurological:_____
5. Allergies: _____
6. Psychiatric History:_____
7. Mental Status: (MMSE Score, if Available)_____
8. Alcohol/Drug/Cig. Use: _____
9. Immunization Hx: (Dates) Flu _____Pneumovax_____
10. PPD: (two-step) Results: Step 1 Date: _____ Result:_____
    Step 2 Date: _____ Result:_____
11. Does Patient have a Living Will (Advance Directive) YES / NO

PHYSICAL EXAMINATION

Blood Pressure_____Weight_____Height _____HR _____

General Appearance: Skin:_____

Head and Neck: E.E.N.T.:_____

Lymph: Heart:_____

Thyroid:_____

Lungs:_____

Abdomen: _____Rectal:_____

Pelvic:_____Breasts:_____

Skeletal (Arthritis? Deformity?):_____

Neuro:_____

Muscle:_____

Lower Extrem. & Feet (prosthesis?):_____

Will adjustment to congregate living be?: EASY / DIFFICULT / UNKNOWN

Functional Dependence:

Communication _____

Ambulation _____

Daily Living Activities _____

Elimination _____

Transfer _____

Total: _____

Scoring:

1 - Independent
2 - Some Dependence
3 - Total Dependence

Interpretation:

5-6	- None
7-8	- Mild
9-10	- Moderate
11 +	- Severe

_____
Name of Examining Physician (Print or Type)

Address_____

_____

_____
Signature

_____
Date of Examination

_____
Phone Number

Rev. 08-30-2018