

Exhibit B
011108-HC

**Heights Crossing
35 Christy Place
Brockton, MA 02301
508-580-4300
508-580-3433 FAX**

PHYSICIAN'S STATEMENT OF MEDICAL CONDITION

Applicant's Name: _____ Date of Birth: _____

Street Address: _____ City _____

I authorize Dr. _____ to release information on my medical conditions to Heights Crossing for consideration for entrance.

Name Date

Dear Physician:

Your patient named above has applied for residency at Heights Crossing in Brockton, MA. Those living at Heights Crossing will receive up to 45 minutes of personal care per day delivered by personal care aide staff and under the supervision of a nurse. **Residents may receive more than 45 minutes per day of care at an additional charge.** We will have a nurse in the building at least 8 hours per day. In addition, we will provide three meals per day, weekly housekeeping, 24-hour hospitality/security services and an active activity schedule. Utilizing the above-mentioned supports, Residents should be able to live independently within their own apartments. The following information will help us to determine whether the applicant is appropriate for Heights Crossing and also, how we will be able to meet their needs. Please complete the following information and mail or fax to us at your very earliest convenience. We are unable to make a decision on your patient's application until we receive this information.

How long has the applicant been your patient? _____

Date of last physical examination: _____

Current medical diagnosis: 1. _____

2. _____

3. _____

Current Health Concerns and Treatments: (Please be as specific as possible.) _____

Please list all medications, prescribed and over the counter, that your patient is currently taking:

Name	Dose	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Does your patient require special dietary considerations? (If yes, please explain.)

Please list all allergies to drugs, foods and chemicals:

Please list dates of surgeries, hospitalizations or major medical events in the past five years:

1. _____
2. _____
3. _____
4. _____
5. _____

Has applicant ever been hospitalized or treated for any psychiatric condition?
(Specify dates, diagnosis and treatments, if known.)

Has applicant ever required treatment for drug or alcohol addiction? (If yes, please give details.)

Please give your opinion regarding the following:

	Yes	No
1. oriented to time and place	_____	_____
2. able to self medicate	_____	_____
3. able to toilet independently	_____	_____
4. experiencing dementia or forgetfulness such as to interfere with safety issues	_____	_____
5. able to live independently with assisted living supports in place as previously described	_____	_____

Please provide any additional information that you think would be helpful in our determining the appropriateness of your patient's application or in our serving her if/when he/she moves in.

Physician' Signature

Date

Physician's Name (please print)

Physician's Address (please print)

Phone Number

To email form please click here