



**60-DAY MEDICAL VERIFICATION FORM**  
**The Village at Brookwood**

The prospective resident named on this form has applied for residency at The Village at Brookwood, a life care retirement community. This form is to be filled out by the resident's physician. The Village at Brookwood Health Clinic reserves the right to contact the health care provider for follow-up information. The signature in Section I authorizes the release of medical information to The Village at Brookwood Health Clinic. Your health care provider may require another authorization from you to release your medical information to us in order to meet Healthcare Privacy Rules. ALL RESIDENT INFORMATION OBTAINED BY THE VILLAGE AT BROOKWOOD WILL BE HELD IN STRICTEST CONFIDENCE.

**SECTION I. IDENTIFYING INFORMATION TO BE FILLED OUT BY THE RESIDENT:**

Name of Resident: \_\_\_\_\_

Location of Residence:            Cottage            Apartment            (please circle)

Scheduled Move-In Date: \_\_\_\_\_ The Village at Brookwood Unit Number \_\_\_\_\_

Current Address: \_\_\_\_\_

Current Phone(s): Home \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact and phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Sex:    M        F                    Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_            Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**Resident Signature**

\_\_\_\_\_

**Date**

Resident: \_\_\_\_\_

**SECTION II. TO BE FILLED OUT BY HEALTH CARE PROVIDER:**

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A. Primary Medical Diagnosis:

- |    |    |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_

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B. Medications:

- |    |     |
|----|-----|
| 1. | 8.  |
| 2. | 9.  |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |
- 

C. Surgeries or Hospitalizations within last five years (include dates and results):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Special Diet (if necessary):

\_\_\_\_\_  
\_\_\_\_\_

- E. Ambulation:     Independent             Walks with assistive device (cane or walker)  
                          Uses scooter/WC, can transfer in/out independently, can walk short distance  
                          Requires transfer assistance             Non-ambulatory

- F. Bathing:         Bathes Self             Minimal Assistance             Total Assistance

G. Mental Status:  Alert/Oriented       Depressed       Confusion/Memory Loss  
 Supervision Required for Safety      Physician involved in care \_\_\_\_\_

Is mental status/condition improved/controlled by medication? Yes    No

Resident: \_\_\_\_\_

H. Immunization History:

Tetanus _____(date)	Hepatitis B _____(date)
Diphtheria _____(date)	BCG _____(date)
Pneumonia _____(date)	PPD (within last 60 days) _____(date)

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please address ability to live in Independent Living Community, with or without assistive devices or adaptive equipment.

\_\_\_\_\_  
\_\_\_\_\_

Patient is capable of living in which of the following level of care, please check one:

- Independent Living
- Assisted Living
- Long Term Care
- Memory Care

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Phone# \_\_\_\_\_