New Horizons
This is home!

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 _____