Villa Marin

A VIBRANT SENIOR LIVING COMMUNITY

APPLICANT'S MEDICAL HISTORY AND PHYSICAL EXAMINATION

Please complete the first page and give to your doctor to complete.

Name of applicant _____

Address _____ Phone (____)_____

City _____ State _____ Zip _____

Date of birth: Month _____ Day _____ Year _____ Age _____

Name of physician (please print): _____

Address _____

_____

Phone (____)_____ FAX No. (____)_____

To any physician, hospital, or clinic:

I HEREBY AUTHORIZE YOU TO GIVE VILLA MARIN HOMEOWNERS' ASSOCIATION ANY INFORMATION THEY REQUEST WITH REFERENCE TO MY MEDICAL HISTORY, OR ADVICE, OR HOSPITALIZATION. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Applicant Date

_____

INSTRUCTIONS TO THE EXAMINING PHYSICIAN

Please return the Medical History and Physician Examination Report to Villa Marin via the following options:

- **Fax to clinic coordinator, Linda Hills, at 415-499-8395**
- **Email to alynn@villamarinhoa.com**

Consideration of your patient's admission cannot continue without this completed form.

- The physical examination need be within the last **three (3) months, and Lab results within 12 months.**
- Any material misrepresentation or omissions may result in rejection or termination of residence and health care agreements.
- Additional tests may be required based on the patient's medical history.

THIS IS A RETIREMENT COMMUNITY, NOT A NURSING HOME. THE HEALTH FACILITIES ARE FOR RESIDENTS WHO BECOME ILL OR INFIRM. NEW RESIDENTS ENTERING VILLA MARIN SHOULD NOT PRESENT AN UNACCEPTABLE RISK.

UTILIZATION OF THE PERSONAL CARE OR SKILLED NURSING FACILITIES. THIS EXAMINATION WILL PROVIDE A DETAILED HISTORY THAT WILL ENABLE OUR MEDICAL DIRECTOR AND ADMISSIONS COMMITTEE TO ASCERTAIN THE ELIGIBILITY OF THE APPLICANT. PLEASE KEEP THIS IN MIND AS YOU FILL OUT THE APPLICANT'S HEALTH HISTORY.

I. MEDICAL HISTORY (Please print)

a. Family history _____

_____

_____

b. Significant illnesses, including psychiatric illness or mental confusion

_____

_____

_____

c. Significant hospitalizations _____

_____

_____

_____

d. Significant surgeries (include date and surgeon's name)

_____

_____

_____

_____

e. List any existing symptoms _____

_____

_____

f. Has there been evidence of substance abuse? Explain. _____

_____

_____

_____

g. Any additional information deemed important for applicant's medical history would be helpful.

_____

_____

_____

_____

II. PHYSICAL EXAMINATION

1. Weight _____ Height _____ Blood Pressure _____ Pulse _____

2. Does the applicant's physical examination reveal abnormalities in any of the following? If yes, give details below:

Head (eyes, ears, nose, throat) _____

_____

Chest (include pulmonary and breast exam) _____

_____

Cardio-vascular _____

_____

Abdominal _____

_____

Genito-urinary (include rectal exam) _____

_____

Skin _____

_____

Bones and joints _____

_____

Neuromuscular _____

_____

Mentation (include results of mental status exam, if done) _____

_____

_____

List of current diagnoses and medications, including dosage _____

_____

_____

_____

EVALUATION

a. Is he/she fully able to live independently?

_____

b. Is he/she able to care for self in case of emergency, i.e. understand instructions and evacuate the premises without assistance?

_____

c. Are you aware of any conditions that might require attendant or skilled nursing care?

_____

_____

d. Are you aware of any condition that might impair the health or comfort of other residents?

_____

_____

e. Are you aware of any vision impairment or eye disease? If yes, give prognosis and treatment.

_____

_____

f. Is there now, or anticipated soon, a need for the use of assistive mobility devices?

_____

_____

g. Date last seen by you and total number of visits in the last 12 months _____

The following lab tests are required within 1 (one) year. All results must accompany this report:

a. Complete blood count Date _____

b. Electrocardiogram printout Date _____

c. Complete urinalysis Date _____

d. Written evaluation of chest X-ray Date _____

e. Comprehensive metabolic panel Date _____

Please note that the following procedures (Pap Smear, Mammogram, PSA) may be requested by the VM Physician on a case by case basis of prospective buyers.

Signature of Physician _____ Date _____

Specialty _____

Address _____

Telephone # _____

Villa Marin

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Villa Marin Application Process

Download the application forms below. When completed mail or deliver to Villa Marin along with the $250 per person application fee.

When submitting your application forms, please be sure to include:

- A copy of your most recent tax return – Federal Form 1040 Pages 1 & 2
- A copy of your Medicare and other medical insurance cards
- Payment of the application fee ($250 per person) via personal check (non-refundable)

All information is kept confidential.
Please fax, mail or deliver your admission package to:

Villa Marin Administration
Attn: Admissions Committee Chair
100 Thorndale Drive
San Rafael, CA 94903-4599

Fax Application Form to clinic coordinator at 415-499-8395