



**DOCTOR'S ASSESSMENT FORM**

FACILITY NAME: Stillwater Gardens Rest Home & Continuing Care

CLIENT NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
\_\_\_\_\_

NEXT OF KIN /ADVOCATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
PHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**DOCTORS ASSESSMENT (Please answer all questions)**

- 1) Are you the applicant's usual G.P.? \_\_\_\_\_
- 2) If so, how long have you known the patient? \_\_\_\_\_
- 3) When did you last see the patient? \_\_\_\_\_
- 4) Do you wish to continue to have over sight of the patient? \_\_\_\_\_
- 5) Has patient been in any other residential care facility/ Hospital within the last 5 years? \_\_\_\_\_  
Name of Hospital: \_\_\_\_\_ Approx Dates: \_\_\_\_\_

**Please list:**

1) All Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Any Drug Allergies: \_\_\_\_\_  
\_\_\_\_\_

3) Present Drug Regime: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



