



2)

ARIZONA STATE VETERAN HOME – PHYSICIAN’S STATEMENT

The following is to be completed and signed by the applicant’s physician

1. Name of Applicant: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_

3. Is this person capable of caring for him/herself? \_\_\_\_\_ YES \_\_\_\_\_ NO

4. Applicant’s current diagnoses:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Applicant’s current medications:

Medication	Dose	Frequency (x per day)	DX for Medication

6. Are special treatments or therapies required for this person? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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7. Could this person be considered a danger to self or to others? \_\_\_\_\_ Yes \_\_\_\_\_ No

8. Have they had a Mantoux TB skin test done in the past 3 months? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please attach copy of the results.

9. Has this person had Pneumovax 23? \_\_\_\_\_ Yes \_\_\_\_\_ No Date: \_\_\_\_\_

10. Has this person had Pneumovax 14? \_\_\_\_\_ Yes \_\_\_\_\_ No Date: \_\_\_\_\_

11. ALLERGIES? \_\_\_\_\_

12. If this person is admitted to the Arizona State Veteran Home will you be the attending physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

13. Please PRINT the following:

Physician's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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Physician's Signature

Date

