



## ARIZONA STATE VETERAN HOME – PHYSICIAN'S STATEMENT

The following is to be completed and signed by the applicant's physician.  
Please attach a copy of the patient's History and Physical as well as a TB test.

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

1. Diet and Diet Consistency: \_\_\_\_\_

2. Activity Orders/Limitations: \_\_\_\_\_

3. Are special treatments or therapies required for this person? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

4. Could this person be considered a danger to self or others? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, please explain: \_\_\_\_\_

5. Have they had a Mantoux TB skin test done in the past 6 months? \_\_\_\_\_Yes \_\_\_\_\_No  
If yes, please attach copy of the results.

6. Has this person had Pneumovax 23? \_\_\_\_\_Yes \_\_\_\_\_No Date:\_\_\_\_\_

7. Has this person had Pneumovax 14? \_\_\_\_\_Yes \_\_\_\_\_No Date:\_\_\_\_\_

8. ALLERGIES? \_\_\_\_\_

9. If this person is admitted to the Arizona State Veteran Home will you be the attending physician? \_\_\_\_\_Yes \_\_\_\_\_No

10. Please PRINT the following:

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

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

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

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

Please return this statement to the Arizona State Veteran Home with a copy of the patient's History and Physical and TB Test results.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date