Take this form to
Licensed Medical Provider
MD / DO / PA / NP

3 - ME

MEDICAL EXAMINATION

If FAXING documents to AFRH, please make a black & white copy before sending the fax so that it will be legible when it is received. Please call and let us know to look for the documents to come through as well – thank you for all your help! We want to prevent any delays in processing applications!

Dear Applicant:

The Armed Forces Retirement Home requires the completion of a comprehensive Medical Examination and current Tuberculosis Screening for all applicants in order to determine eligibility for residence.

Please provide this form to a licensed medical provider [must be a Physician (M.D. or D.O.), Nurse Practitioner (NP) or Physician's Assistant (PA)] to complete. In order to be considered for residency, this form will need to be submitted along with the completed Application Form and Functional Assessment.

Please review the form before submitting and ensure all items have been completed and that your provider has initialed and signed in all of the appropriate fields. Incomplete forms will delay processing of the application.

Thank you
AFRH

RETURN EVALUATION TO:

ARMED FORCES RETIREMENT HOME
PUBLIC AFFAIRS OFFICE #584
3700 NORTH CAPITOL ST, NW
Washington, DC 20011-8400
Fax Number: (202) 541-7519
Telephone: (800) 422-9988 opt. 1

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Personnel and Readiness; 24 U.S.C. 401, Armed Forces Retirement Home; DoD Directive 5124.09 Assistant Secretary of Defense for Personnel and Readiness Force Management; DoD Instruction 1000.28, Armed Forces Retirement Home (AFRH); and E.O. 9397 (SSN), as amended.

PURPOSE: To determine and verify eligibility for admission to the AFRH.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the records contained herein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: To the Federal Reserve for processing the debt on the resident account; To authorized contractors or vendors for the purpose of providing medical services to the residents of the Armed Forces Retirement Home; To any Federal agency which provides medical services to residents of the Armed Forces Retirement home; To the Inspector General of the Department of Defense or his/her designee, for conducting inspections of AFRH records; To a Federal agency, or an organization or person contracting with the AFRH for information needed in the performance of official duties related to reconciling or reconstructing data files, compiling descriptive statistics, and/or making analytical or financial studies to support the function for which the records were collected and maintained; Law Enforcement Routine Use; Congressional Inquiries Disclosure Routine Use; Disclosure of Information to the National Archives and Records Administration Routine Use; Disclosure to the Merit Systems Protection Board Routine Use; and Data Breach Remediation Purposes Routine Use.

The applicable system of records notice is DPR 38 DoD, Armed Forces Retirement Home electronic Resident Information System (eRIS) and is available at: (ADD LINK WHEN PUBLISHED).

DISCLOSURE: Voluntary; however, failure to provide the required information may result in the delay or denial of admission.

ARMED FORCES RETIREMENT HOME

Medical Examination

Form Completed by a Licensed Medical Provider

3 - ME

Last Name	First Name	MI	Birthdate

Street Address	City	State	Zip Code

THIS FORM IS TO BE COMPLETED BY THE APPLICANT'S LICENSED MEDICAL PROVIDER

Physician (M.D. or D.O.), Nurse Practitioner (NP), or Physician's Assistant (PA) ONLY

Patient: _____ Age: _____

Street: _____ DOB: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

○ Male	○ Tobacco Use	○ Currently Lives Alone:	☐ Single ☐ Separated ☐ Divorced ☐ Widowed
○ Female	○ Non-Tobacco	○ Lives with Family/Other:	

Past medical history - Please indicate if the person has ANY history of the following conditions:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	1=Mild > 4=Severe
○	○	Anticoagulation Therapy	○	○	Hospitalizations (Medical)	○	○	Hospitalizations (Psychiatric)	
○	○	Cardiovascular Disease / MI	○	○	Stroke	○	○	Prescription Drug Abuse (within 1 year)	
○	○	Congestive Heart Failure	○	○	Vision Loss / Legally Blind	○	○	Illegal Drug Abuse (within 1 year)	
○	○	COPD / Asthma	○	○	Head Injuries	○	○	Alcohol Abuse (within 1 year)	
○	○	Oxygen Therapy	○	○	Seizures / Epilepsy	○	○	Psychiatric or Mood Disorders	
○	○	Gastrointestinal Disorders	○	○	Parkinson's Disease	○	○	Psychosis	
○	○	Colostomy	○	○	Immune Disorders	○	○	Memory Loss	1 2 3 4
○	○	Diabetes	○	○	Rheumatoid Arthritis	○	○	Chronic Pain	1 2 3 4
○	○	Amputations	○	○	Dementia / Alzheimer's	○	○	Depression	1 2 3 4
○	○	Cancer	○	○	Other _____	○	○	PTSD	1 2 3 4

Describe history if any of the above items are marked yes and indicate whether issue is ongoing, in remission, or resolved:

_____

_____

List all allergies, including medications, foods, latex, etc.:		
1.	4.	7.
2.	5.	8.
3.	6.	9.

List all current medications – attach list as needed		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

MEDICAL RECONCILIATION:

I confirm that the medications annotated above are accurate and current. X _____ (Provider initial here to confirm list)

ARMED FORCES RETIREMENT HOME

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Last Name	First Name	MI	Birthdate

Street Address	City	State	Zip Code

Physical Examination: (completed by provider ONLY (MD, DO, NP, or PA) **Date of Exam**:_____

NOR	ABN	Indicate whether or not the following are normal? - If abnormal, explain symptoms/signs:
○	○	HEENT (Head, eyes, ears, nose, throat):
○	○	Cardiovascular:
○	○	Lungs:
○	○	Thyroid:
○	○	Abdomen:
○	○	Lymphatic:
○	○	Neurological:
○	○	Extremities:
○	○	Skin:
○	○	Neck:

Current Vital Signs: All vital signs must be recorded on the date of physical examination – ANY blank areas will delay processing.

Blood Pressure:		**Temperature:**		**Height:**	
Respiratory Rate:		**Pulse:**		**Weight:**	

Activities of Daily Living: (completed by provider ONLY (MD, DO, NP, or PA)

Yes	No	Able to complete task INDEPENDENTLY? If some assistance is required/recommended, provide explanation:
○	○	Ambulation / Mobility (may use device):
○	○	Bathing / Showering (may use device):
○	○	Transfer from one position to another:
○	○	Self-Directed Feeding:
○	○	Dressing / Undressing:
○	○	Toileting / Continence:
○	○	Self-Directed Medication Management:

Indicate whether or not the following apply:

Yes	No		Yes	No	
○	○	**Ability to Communicate Needs**	○	○	**Partial Paralysis / Paralysis / Amputation**
○	○	**Lack of Verbal Communication**	○	○	**Peg Tube / Colostomy**
○	○	**Corrective Lenses / Low Vision**	○	○	**Urinary Catheter**
○	○	**Dentures**	○	○	**Incontinence ☐ Bowel ☐ Bladder**
○	○	**Hearing Aids / Low Hearing**	○	○	**Other:**

Tuberculosis Screening Test: Applicant is required to take a Tuberculosis Screening Test for Admission to AFRH

TST Screening Test:	☐ **NEGATIVE** ☐ **POSITIVE** mm Induration: _____mm
Date of TST Test Results	MM/DD/YY:
If Positive, list conversion date:	MM/DD/YY:
If Positive, Chest X-Ray date:	MM/DD/YY:
Chest X-Ray results and findings:	
Interferon Gold Test (IGRA) results:	

Provider's Signature/Credentials: x _____ Date: _____

Stamps and/or copies of test results are accepted but the provider MUST have handwritten signature, credentials, & date in this field.

ARMED FORCES RETIREMENT HOME

Medical Examination

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Last Name	First Name	MI	Birthdate

Street Address	City	State	Zip Code

Mental Status and Behavior: (completed by provider ONLY (MD, DO, NP, or PA)

Please provide an explanation of any observations:

1	2	3	4	5	KEY: 1=NEVER 2=RARELY 3=SOMETIMES 4=FREQUENTLY 5=ALWAYS
○	○	○	○	○	Shows signs of memory loss:
○	○	○	○	○	Shows signs of depression:
○	○	○	○	○	Shows signs of wandering:
○	○	○	○	○	Shows signs of confusion:
○	○	○	○	○	Hostile, aggressive, or combative behaviors:

Yes	No	Indicate if any of the following are true – if so, please provide explanation (attach reports, findings or lists as needed)
○	○	Prescribed any psychiatric medications in last 5 years:
○	○	Substance abuse/dependence in last 12months:
○	○	Represents a risk or danger to others:
○	○	Represents a danger to self or poses risk of suicide:
○	○	Expresses a desire to die or lacks the will to live:
○	○	Incapable of living in a community environment:

Orientation

Yes	No	Describe any issues regarding orientation:
○	○	Person:
○	○	Place:
○	○	Date / Time:
○	○	Situation:

Level of Care:

Provider select recommended level of care for this individual: Please write **initials** inside the appropriate box:

☐ **Independent Living**	Individual does not require assistance in order to complete daily activities
☐ **Assisted Care**	Includes some aid in activities of daily living, diversionary activities, and protection from hazards and/or minimal assistance from staff
☐ **Skilled Care**	Includes professional nursing care and assessment on a daily basis due to a serious condition, which is unstable, or a rehabilitative, therapeutic regime requiring a professional staff

** Stamps are accepted but the provider MUST sign with handwritten signature, license number, and date or the form will be returned.*

Please Print (Stamp is acceptable)	
Provider's Name:	
Credentials:	
Street Address:	
City, ST Zip	
Phone Number:	
Fax Number:	

Signature and License Number Required
X

Signature Date

License Number State

END