

# Nevada State Veterans Home Physician's Medical Certificate

## Section IV

This Certification is Valid For Three Months

Please print

I certify that \_\_\_\_\_  
Last Name First Name Middle initial

requires 24-hour skilled nursing care. \_\_\_\_\_  
Physician's Signature Date of Exam

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Male  Female  Allergies: \_\_\_\_\_

Current Diagnosis: \_\_\_\_\_

Other Pertinent History: (include past medical problems, complaints, etc.)

Hospitalization and operations for past 90 days:

Physical Examination: Height \_\_\_\_\_ Weight \_\_\_\_\_

Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ B/P \_\_\_\_ / \_\_\_\_

Skin Condition/Pressure Areas: Please describe condition, site, stage, etc. \_\_\_\_\_

Current diet: \_\_\_\_\_

Significant other positive findings:

