ALL GENERATIONS
ADULT DAY CENTER

PHYSICIAN'S ADMITTING MEDICAL EVALUATION

CLIENT NAME:_____ SSN:_____

ADDRESS:_____

DOCTOR'S NAME:_____

ADDRESS:_____

PHONE:_____ HOSPITAL AFFILIATION:_____

LAST PHYSICAL EXAM OR LAST OFFICE VISIT (DATE):_____

VITAL SIGNS: BP_____ T_____ P_____ R_____ Ht_____ Wt_____

CHEST X-RAY/MANTOUX DATE/RESULTS_____

PRIMARY DIAGNOSIS: _____

SECONDARY DIAGNOSIS: _____
OTHER:
IS CLIENT AWARE OF DIAGNOSIS? __ YES __ NO
A. MEDICAL HISTORY:_____

B. SURGICAL HISTORY:_____

C. PLEASE INDICATE ANY CONDITION FOR WHICH CLIENT IS CURRENTLY RECEIVING TREATMENT: __ UTI __ Diabetes __ Hypertension
Coronary Artery Disease __ Cerebral Vascular Disease __ History of TB

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_____Peripheral Vascular Disease ___ Emphysema ___ Chronic Bronchitis
_____Asthma ___ Arthritis ___ Peptic Ulcer __Hiatal Hernia
_____Cancer ____Cirrhosis ____ Thyroid (hyper, hypo) ___ Glaucoma ___ Cataracts
_____Prostate ____Parkinson's __Heart Disease ____Dementia ____Alzheimer
_____Other:

(Specify)_____
_____
_____

D. ALLERGIES: DRUG:_____

ALLERGIES FOOD:_____

E. PSYCHIATRIC/COGNITIVE IMPAIRMENT HISTORY:

MAY PATIENT TAKE PART IN ROOM EXERCISES? ___ YES ___ NO

ACTIVITY LEVEL: ____ ACTIVE ___ PASSIVE ____ AS TOLERATED

ANY PHYSICAL LIMITATIONS: ___ YES ___ NO IF YES, DESCRIBE:

Please attach a list of all prescription medication and over the counter medications prescribed for _____ to this form.
Prescription list must include:

PRESCRIPTION MEDICATION NAME, OVER THE COUNTER MEDICATION NAME, MEDICATION DOSAGE, FREQUENCY, ROUTE

IS CLIENT COMPLIANT WITH MEDICATION? YES NO

MAY CLIENT ADMINISTER OWN MEDICATION? YES NO

SPECIAL DIET:

SPECIAL EQUIPMENT NECESSARY (OXYGEN, Dressing, etc.)

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ORDER FOR REHABILITATION EVALUATION/TREATMENT:

OCCUPATIONAL THERAPY

PHYSICALTHERAPY

SPEECH THERAPY

PHYSICIAN ORDERS FOR ACTIVITIES WITHIN THE DAY CARE PROGRAM

Encourage Participation in:

__Social Activities __Mental Activities __Group Activities __Spiritual Activities

__Physical Activities __Individual Activities

STANDING ORDERS:
1) NURSE MAY INSTITUTE TREATMENT FOR PRESSURE AREAS, ULCERS, OR OPEN AREAS USING NON-PRESCRIPTION OINTMENTS, PRN.
2) SOILED DRESSINGS MAY BE REMOVED AND DRY STERILE DRESSING APPLIED, PRN
3) TYLENOL MAY BE ADMINISTERED FOR COMPLAINTS OF HEADACHE, MUSCLE ACHE, OR STIFFNESS, UNLESS CONTRAINDICATED PRN
4) FOR MINOR BURNS, COLD MOIST COMPRESS AND SILVADENE CREAM MAY BE APPLIED, PRN

5) FOR GOOD HYGIENE: MAY HAVE SHOWER AT CENTER, UNLESS CONTRAINDICATED PRN
6) MYLANTA 15-30 cc PRN FOR UPSET STOMACH, BURNING (HEARTBURN), GAS
7) KAOPECTATE 1-2 TABLESPOON(S) PRN AFTER EACH DIARRHEA STOOL

I HAVE EXAMINED THE ABOVE NAMED PERSON AND BELIEVE HIM/HER TO BE FREE FROM COMMUNICABLE DISEASE, INCLUDING ACTIVE TUBERCULOSIS.

I HEREBY RECOMMEND _____ FOR ADULT DAY CARE SERVICES.

_____ _____

PHYSICIAN SIGNATURE DATE