Today's Date: _____

Lifescape Adult Day Program: Physician's Form

Must be completed by family physician & returned to ADS prior to attendance.

Client Name: _____ DOB: _____ Age: _____

Allergies: _____

Height	Weight	Blood Pressure	Pulse	Respiration

Medical Information/Diagnosis (Check all that apply)

Dementia: □Alzheimer's □Vascular □Lewy Bodies □Pick's Disease □Wernicke-Korsakoff □Creutzfeldt-Jakob **Stage:** □Mild/Early Stages □Mid-stage □Severe/Late Stage
Diabetes: □Type I □Type II □Insulin □Oral □Diet Controlled
Cardiac □Coronary Artery Disease □Arrhythmia □Heart Failure □Angina □Pacemaker □Hypertension
Pulmonary □Asthma □Chronic Bronchitis □COPD □Emphysema
Stroke □CVA _____ □TIA _____
Seizures □History of Seizures □History of Epilepsy
Incontinence □Bladder □Bowel
Other Medical □Arthritis □Osteoporosis □Parkinsons'
Sensory □Hearing Loss □Cataracts □Glaucoma □Macular Degeneration □Speech Issues
Behavioral □Depression □Anxiety □Bipolar Disorder □Schizophrenia □Hx violent/aggressive behavior
Other Medical Information/Diagnosis (please list or attach list):

Client Current Medication List (attach additional sheet if needed)

Medications (Please list All)	Dosage	Frequency
***Please attach list**		

***Is this client able to self-medicate while at Adult Day Program? □Yes □Yes with reminders □No**

Medications to be given @ Adult Day Program by Nurses (attach additional sheet if needed)

Medication	Dose	Frequency	Route

ALL MEDICATIONS MUST BE IN ORIGINAL OR MOST CURRENT BOTTLE

Dietary Considerations

*Please check all that apply

□ NAS (no added salt) □ NCS (no concentrated sweets) □Mechanical Soft □Cut Food

Health Maintenance/Immunizations

***Please note: A TB test is required of all clients. Initial TB test must be within the last 30 days of admission. Patient must have yearly TB test**

TB Test Date: _____ **TB Test Results: _____**

Flu Shot Date: _____ (If applicable)

Pneumonia Shot Date: _____ (If applicable)

Client is free of communicable diseases or infections: □**Yes** □**No***

If no, please state disease or infection: _____

_____

Physician Information

Physician Name:	**Please Return this Completed Form to:** **Lifescape Adult Day Program** 1330 South Alpine Rd, Rockford 61108 815-987-1934 (Fax) 815-964-2433 (Phone)
Office Address:	
Office Phone #:	
Office Fax #	

I certify that I have examined this person within the last three months and have reviewed his/her health history. I find him/her appropriate and able to participate in Adult Day Program.

Physician Signature: _____ Date: _____

Physician Name (Please print): _____

(For Adult Day Program Nurse Use)

Date physician's form received: _____ Received By: _____

Received Via: □In person (drop off) □Mail □Fax □Other: _____

Adult Day Program Nurse Notes:

_____

_____

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