LIFESCAPE

Lifescape Adult Day Program: Physician's Form

Must be completed and returned to ADP prior to attendance.

Client Name: _____ DOB: _____ Age: _____

Height	Weight	Blood Pressure	Pulse	Respiration	**ALLERGIES:**

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
Psychiatric behavior	☐Depression ☐Anxiety ☐Bipolar Disorder ☐Schizophrenia ☐Hx violent/aggressive
Other Medical Information/Diagnosis (please list or attach list):	

Client Current Medication List

Medications	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

Dietary Considerations

*Please check all that apply

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

Client Name: _____ **D.O.B** _____

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:** _____

Influenza Vaccine Date: _____ (If applicable)

Patient received COVID-19 Vaccine: ☐**No** ☐**Yes**

COVID-19 Vaccine **1st** Dose Date: _____ COVID-19 Vaccine: **2nd** Dose Date: _____

Patient 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 patient within the last three months and have reviewed patient's health history. I find patient appropriate and able to participate in Lifescape Adult Day Program.

Physician Signature: X _____ 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: _____

Notes: _____
_____
_____
_____
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