Lifescape Adult Day Program: Physician's Form

Must be completed and returned to ADP prior to 1st day of attendance and repeated annually.

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 □ Other_____ **Stage:** □Mild/Early Stage □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 Year_____ □TIA Year_____
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: □Depression □Anxiety □Bipolar Disorder □Schizophrenia □Hx violent/aggressive behavior
***Other Medical Diagnosis / Information not mentioned above (please 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

If taking meds DURING the Adult Day Program hours please list them below. This includes PRN, accu-checks, insulin, eye drops, inhalers & OTC medications (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 prior to admission and no more than 30 days old. *Patient must have yearly TB test. Any one of the three tests listed below are acceptable*:**

Quantiferon Test Date_____ Quantiferon Test Results:_____

TB SkinTest Date: _____ TB Test Results: _____

Chest Xray Date:_____ Chest Xray Results:_____

Influenza Vaccine Date: _____ (If applicable)

COVID-19 Vaccine Date: _____(most recent)

Patient is free of communicable diseases or infections and can participate in this Adult Day Program:

☐**Yes** ☐**No***

*If no, please state disease or infection:

_____

_____

Physician Information

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

Received physician's form: ☐In person ☐Mail ☐Fax ☐Other: _____ Date:_____ Initial_____

Received med list: ☐In person ☐Mail ☐Fax ☐Other: _____ Date:_____ Initial_____

Notes: _____

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