

Page Robbins Adult Day Care Center

1961 South Houston Levee Road
Collierville, Tennessee 38017
901-854-1200
Fax: 901-854-5726

Physician's Form

(Note to Physician: The client and their caregiver below are completing an application for admission to Page Robbins Adult Day Care Center. We provide day services to adults with dementia and/o who are frail. Please complete this 3 page form and mail/fax it to our center or give to the primary caregiver. Thank you.)

General Information

Client Name _____
(First) (Middle) (Last)

Street Address _____
City and State _____

Date of Birth _____ Male Female

Responsible Party/
Legal Guardian _____ Phone _____

Height _____ Weight _____ lbs Blood Pressure _____

Drug/Allergies _____ Latex Allergy: _____

(Please note that a chest XRay **OR** a Skin Test must have been completed within the last 6 months.)

Chest X-Ray: Yes _____ No _____ Date: _____ Results: _____

PPD Skin Test: Yes _____ No _____ Date: _____ Results: _____

Identification and Background Information

Last Medical Assessment Date _____ by _____

Bowel and Bladder:

Client has complete control of bowel and bladder Yes No
If No, Please Explain: _____

- Client has one of the following:
- 1. External Catheter _____
 - 2. In-dwelling Catheter _____
 - 3. Pads, Briefs _____
 - 4. Ostomy (Please Specify) _____
 - 5. None _____
 - 6. Other _____

Client has been tested for a Urinary Tract Infection in the last 60 days Yes _____ No _____
If Yes, Medication Prescribed: _____

Disease Diagnosis (Please check if yes)

Heart/Circulation

Arteriosclerotic Heart Disease
Hypertension
Hypotension

Congestive Heart Failure
Transient Ischemic Attack (TIA)
Other Cardiovascular Disease: _____

Neurological

Alzheimer's disease
Dementia, non-specific
Aphasia
Parkinson's disease
CVA
Other (Please specify) _____

Pulmonary

Emphysema
Asthma
COPD
Other: (Please specify) _____

Psychiatric/Mood

Anxiety Disorder
Depression
Other: (Please specify): _____

Vision

Cataracts
Glaucoma
Uses Glasses

Hearing

Some Hearing Loss Right Ear Left Ear
Uses Hearing Aid Right Ear Left Ear

Other:

Anemia
Arthritis
Cancer (Please Specify Type) Type: _____
Diabetes Mellitus
Insulin Dependent
Hypothyroidism
Osteoporosis
Seizure disorder
Hiatal Hernia
Other: _____

7. Past Surgical History: _____
8. Other Health Conditions: _____

Existing Conditions:

Constipation	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Dizziness/Vertigo	<input type="checkbox"/>	Edema	<input type="checkbox"/>
Hallucination/Delusions	<input type="checkbox"/>	other: _____	

Ambulation:

Independent

Uses assistive equipment

Please specify: _____

Current Medications

(Please include: Name, Dosage, Frequency and Reason for Medication)

Non-Prescription Drugs (Given at the center PRN according to label if symptoms occur)

Tylenol 500 mg, 1 tab every 3-4hours	Yes _____	No _____
Maalox 2-4 tsps four times per day	Yes _____	No _____
Imodium AD 1 tab	Yes _____	No _____
Robitussin Cough Syrup	Yes _____	No _____

I certify that _____ is free from Communicable Disease

 (Client's Name)
 and able to participate in an Adult Day Care Program.

_____ Physician (Please sign and Print Name)	_____ Date
_____ Physician Address	_____ Physician Phone Number