Generations Crossing
Caring for children & adults together

PHYSICIAN'S REPORT

This report must be completed and signed by a physician to indicate if adult day care services are appropriate for the person named below. Physicians should note that, as is the case with all adult day care centers, Generations Crossing Adult Day Care Center is not licensed to provide convalescent care and is NOT a medical facility.

Participants Name _____ S.S. # _____

Address _____ Phone: _____

Date of Examination _____

1. Diagnoses and/or Significant Medical Problems

CURRENT DIAGNOSIS	YES	SPECIAL ATTENTION REQUIRED	ACTIVITY RESTRICTIONS
Alzheimer's Disease			
Anemia			
Arthritis/Gout			
Asthma			
Blindness/Vision			
Bowel/Bladder Control Problems			
Cerebral Palsy			
Depression/Emotional Illness			
Diabetes			
Diarrhea			
Dementia (not Alzheimer's)			
Emphysema, Bronchitis			
Endocrine Disorder			
Epilepsy			
Fainting Spells			
Gastro-Intestinal Problems			
Heart Trouble			
Hearing Problems			
Hepatitis			
High Blood Pressure			
Intellectually Disabled			
Kidney Disease			
Malignancy			
Psychiatric Illness			
Skin Disorders			
Speech/Swallowing			
Stroke			
Tuberculosis			
Ulcers			
Urinary Tract Problems			

A. Physical _____WNL _____Other (specify) _____

B. Mental and/or emotional _____WNL _____Other (specify) _____

C. Significant past history _____WNL _____Other (specify) _____

D. Any other disease or condition not mentioned on previous page:

_____

_____

_____

E. Will this person wander off if not closely attended? _____ Yes _____ No

F. Will this person do harm to self, others or property without constant supervision?
_____ Yes _____No

2. Special Requirements/Recommendations for Care

A. Medications

Name	Dosage	Frequency	Route

B. Allergies _____ ASA _____PCN _____Other (specify below)

_____

C. Diet _____ As Tolerated/select _____Supplements _____Assistance Required

_____Special Needs: _____

_____Food intolerances: _____

D. Therapy/Other Services Currently Receiving (Please give agency name and phone number) Needed in Day Care?

Physical Therapy _____ _____

Speech Therapy _____ _____

Occupational Therapy _____ _____

In Home Care _____ _____
(personal, nursing, home health agency, etc.)

E. Physical Restrictions/Limitations

_____ No Restrictions _____Assistive Device _____Poor Endurance

_____ Other (specify): _____

3. Is this person physically and mentally able to make an exit from the building in an emergency without assistance (i.e. without another person, wheelchair, walker, leg prosthesis or other device)?
_____Yes _____ No

If assistance is needed, what type? _____

4. Is this person free of tuberculosis in a communicable form?
_____Yes _____No
Type of test(s):_____
Date of test(s): _____ Test results: _____

EXAMINATION FOR TUBERCULOSIS IS TO BE COMPLETED WITHIN 30 DAYS PRIOR TO ACCEPTANCE FOR ADMISSION TO ADULT DAY CARE OR WITHIN 30 DAYS PRIOR TO ADMISSION.

Inappropriate for test to be given _____ Yes _____ No
If Yes, why? _____

5. Is this person capable of administering his/her own medications?
_____ Yes ____ No

6. Permission is given to administer acetaminophen, 500 mg, one or two tablets PO for minor complaints? _____ Yes _____ No

7. Verification of Above Information:

MD Signature _____ Date _____

Print/Type Physician Name _____

Address _____

Phone _____