445 Willard Ave
Newington, CT 06111

Client Name_____ Date of Exam_____
Physician Name_____Phone #_____
Address_____ Fax #_____
All Active Medical Diagnoses and Problems: Please List
1._____2._____
3._____4._____
5._____6, _____
7._____8._____
9._____10._____
Does Client have a psychiatric disorder or dementia?_____
If so, degree of severity_____Treating Psychiatrist_____
Date of most recent Mantoux PPD_____Chest Xray_____
TUBERCULOSIS SCREENING IS REQUIRED WITHIN 6 MONTHS OF ADMISSION .
Results of most recent Physical Exam:B.P_____Heart Rate_____Weight_____
Any significant findings:_____
_____
_____
Allergies to Medication or Food_____
MEDICATIONS:
The Family Adult Day Care Nurse can only administer medications ordered by the client's Physician. Please list all medications with doses and instructions._____
_____
_____
_____
DIETARY RESTRICTIONS_____
Are there any other Health issues that **Family Adult Day Care** should be aware of?
_____
_____

Physician's Signature_____Date_____