Alzheimer's & Dementia CARE SERVICES

ADULT DAY CENTER - PHYSICIAN FORM

Name of Applicant: _____ Hospital records located at: _____

Applicant's Date of Birth: _____

DEMENTIA

Has the applicant been diagnosed with Alzheimer's disease or a related dementia? *(Check one)* _____ Yes _____ No

What was the diagnosis? _____ Date of diagnosis: _____

TUBERCULOSIS SCREENING

Date of last negative chest x-ray: _____ Date of last negative skin test: _____

MEDICAL HISTORY			
Does the patient have a history of…	**Yes**	**No**	***Comments***
Stroke			Date of last stroke:
Paralysis			
Heart Disease			
Parkinson's Disease			
Diabetes			Insulin dependent? Yes No
Cancer			
Seizures			Date of last seizure:
Depression			
Aphasia			
ALLERGIES/DIETARY RESTRICTIONS			
Allergies and Restrictions	**Yes**	**No**	***Describe allergies or restrictions***
Drug allergies			
Food allergies			
Dietary restrictions			**Diet:**_____

MEDICATIONS

Please list any medications that the applicant is taking and any side effects of which Adult Day Center staff should be aware.

Medication	*Frequency*	*Side Effects*

Alzheimer's and Dementia Care Services of Northwestern Ohio

2500 North Reynolds Road, Toledo, Ohio 43615
Phone: (419) 720-4940 Fax: (419) 720-4941

Are there any physical limitations or medical considerations that would restrict the applicant from attending an Adult Day Center?

____ Yes ____ No *If yes, please specify:*_____

Physician name *(print):* _____ Physician signature: _____

Phone: (_____)_____ Fax: (_____)_____

Date Completed: _____

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