

Saint Agnes Adult Day Service Center
1859 Harrison Boulevard
Valparaiso, Indiana 46385
Phone: (219)477-5433
Fax: (219)462-9553

To the examining physician:

A physical examination is required for participants of Saint Agnes Adult Day Service Center. Our purpose is to assess the client's ability to participate in our center activities as well as to be able to give better care if the client should become ill. We shall be glad to carry out any instructions you have for continued treatment or medical supervision while the client is in our care.

Doctor _____ Participant _____

Special Diet Order _____

Vital Signs BP _____ T _____ P _____ R _____ Ht _____ Wt _____

Primary Diagnosis _____

Secondary Diagnosis _____

Other _____

Please indicate any condition for which this client is receiving treatment

UTI _____ Diabetes _____ Hypertension _____ Coronary Artery Disease _____

Cerebral Vascular Disease _____ Peripheral Vascular Disease _____ Emphysema _____

Chronic Bronchitis _____ Asthma _____ Arthritis _____ Peptic Ulcer _____

Hiatal Hernia _____ Cancer (specify) _____ Alzheimer's _____ COPD _____

Cirrhosis _____ Thyroid (hyper, hypo) _____ Glaucoma _____ Cataracts _____

Prostate _____ Parkinson's _____ Heart Disease (specify) _____

Dementia _____ Depression _____ Epilepsy _____ Multiple Sclerosis _____

Traumatic Head Injury (specify) _____

Mental Health Disorder (specify) _____

FREE FROM COMMUNICABLE DISEASE Yes _____ No _____

TB test given within three months of admission Date _____ Results _____

Chest X-ray (required if positive TB test – To be done within 6 months of admission) _____

Results _____

Pertinent past medical history _____

Allergies _____

May this patient take part in range of motion exercise activities? Yes _____ No _____

Any physical limitations? Yes _____ No _____

Please describe _____

Physician _____

Patient _____

Please list medications that your patient is taking.

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Medication Name _____

Time _____ Dosage _____

Please list additional medications on bottom.

Please add pertinent information. Is client compliant with medications? _____

Please indicate which of the following may be given with supervision and following label instructions:

Tylenol _____ Aspirin _____ M.O.M. _____ Dulcolax Supp. _____ O.T.C. Antacid _____

Fleets Enema prn. _____

I authorize periodic Nursing Physical Assessment of this client by

ADULT DAY CARE REGISTERED NURSE

Date _____ Physician's Signature _____

Physician's Address _____