GENERATIONS CENTRAL ADULT DAY CENTER

Participant Physical Examination

Patient Name:_____ **DOB:** _____

Address: _____ **Phone #:**_____

_____ **Date of Exam:**_____

Diagnosis(es) and Significant Medical Issues:

Diagnosis/Medical Issue	Diagnostic Code

Blood Pressure _____/_____**Pulse**_____ **Height**_____ **Weight**_____

Allergies ☐ No Known Allergies

☐ Medication Allergies _____ Reaction_____

☐ Food/Other Allergies __ _____Reaction_____

Special diet or food intolerance(s): ☐ None

_____

_____

Restrictions or limitations on physical activities or program participation: ☐ No restrictions

_____

_____

Is this individual considered:

□ Ambulatory

□ Non-ambulatory Assistive Device(s)_____

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Therapy, treatments or procedures this individual is undergoing or should receive and the name of the provider:

☐ No additional therapies/treatments or procedures are needed at this time.

Type of Therapy, Treatment or Procedure	Provider name

Current Prescription and Over the Counter Medications ☐ See Attached List ☐ No Medications

*Use * to indicate OTC meds*

Medication	Dosage	Route	Frequency of Administration	Reason for Medication

Is this individual:

□ Capable of administering his/her own medications without assistance.

□ Not capable of administering his/her own medications without assistance.

Is this individual:

□ Physically and mentally capable of self preservation by being able to respond to an emergency - *either by moving to a safe refuge area or exiting a building without the assistance of another person (even if he/she may require the assistance of a wheelchair, walker, cane prosthetic device or a single verbal command).*

□ Not capable of self-preservation without the assistance of another person, because of a physical or mental impairment.

*If this is a pre-admission physical exam, please attach **TB** screening form.

_____ _____

Signature of Physician Date

_____

Physician Printed Name

_____

Physician Address

_____ _____

Phone Number Fax Number