St. Agnes Adult Day Service Center

1859 Harrison Boulevard

Valparaiso, IN 46385

219-477-5433

219-462-9553-fax

To the examining physician:

 A physical examination is required for participants of St. Agnes Adult Day Service Center. Our purpose is to assess the participant’s ability to participate in our center activities as well as to be able to give better care if the participant should become ill.

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_

**ALLERGIES**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vital signs BP\_\_\_\_\_\_\_\_\_\_\_ T\_\_\_\_\_\_\_\_\_ P\_\_\_\_\_\_\_\_\_\_\_\_\_ R\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet Order\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please indicate any condition for which this patient is receiving treatment**

Alzheimer’s disease\_\_\_\_\_\_\_\_ Dementia \_\_\_\_\_\_\_\_UTI\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_ Hypertension\_\_\_\_\_\_

Arthritis\_\_\_\_\_\_\_\_ Coronary Artery Disease\_\_\_\_\_\_\_\_ Cerebral Vascular Disease\_\_\_\_\_\_\_\_ COPD\_\_\_\_\_\_\_\_

Emphysema\_\_\_\_\_\_\_\_ Chronic Bronchitis\_\_\_\_\_\_\_\_ Peripheral Vascular Disease\_\_\_\_\_\_\_\_ Asthma\_\_\_\_\_\_

Peptic Ulcer\_\_\_\_\_\_\_\_ Hiatal Hernia\_\_\_\_\_\_\_\_\_ Cancer (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cirrhosis\_\_\_\_\_\_\_\_ Thyroid (hyper, hypo) \_\_\_\_\_\_\_\_ Glaucoma\_\_\_\_\_\_\_\_ Cataracts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate\_\_\_\_\_\_\_\_Parkinson’s disease\_\_\_\_\_\_\_\_ Heart Disease (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression \_\_\_\_\_\_\_\_ Epilepsy \_\_\_\_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_\_\_\_

Traumatic Head Injury (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Disorder (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARTICIPANT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Pertinent past medical history\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Free from communicable disease Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

TB test given Date \_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_

Chest x-ray (required if positive TB test) See chart for results.

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

Any physical limitations? Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST MEDICATIONS THAT YOUR PATIENT IS TAKING:**

Medication name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Time\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Time\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Time \_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Time \_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Time \_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Time \_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARTICIPANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is patient compliant with medications? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

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

Tylenol\_\_\_\_\_\_\_\_ Aspirin\_\_\_\_\_\_\_\_ M.O.M.\_\_\_\_\_\_\_\_ Dulcolax Supp\_\_\_\_\_\_\_\_ O.T.C. Antacid\_\_\_\_\_\_\_

Fleets enema \_\_\_\_\_\_\_\_ Imodium/antidiarrheal \_\_\_\_\_\_\_\_ Ibuprofen \_\_\_\_\_\_\_\_

I authorize periodic nursing physical assessment of this patient by nurse.

Date \_\_\_\_\_\_\_\_\_ Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_