



PHYSICIAN'S REPORT

This report must be completed and signed by a physician to indicate if adult day care services are appropriate for the person named below. Physicians should note that, as is the case with all adult day care centers, Generations Crossing Adult Day Care Center is not licensed to provide convalescent care and is NOT a medical facility.

Participants Name _____ D.O.B. _____

Address _____ Phone: _____

Date of Examination _____

1. Diagnoses and/or Significant Medical Problems

CURRENT DIAGNOSIS	YES	SPECIAL ATTENTION REQUIRED	ACTIVITY RESTRICTIONS
Alzheimer's Disease			
Anemia			
Arthritis/Gout			
Asthma			
Blindness/Vision			
Bowel/Bladder Control Problems			
Cerebral Palsy			
Depression/Emotional Illness			
Diabetes			
Diarrhea			
Dementia (not Alzheimer's)			
Emphysema, Bronchitis			
Endocrine Disorder			
Epilepsy			
Fainting Spells			
Gastro-Intestinal Problems			
Heart Trouble			
Hearing Problems			
Hepatitis			
High Blood Pressure			
Intellectually Disabled			
Kidney Disease			
Malignancy			
Psychiatric Illness			
Skin Disorders			
Speech/Swallowing			
Stroke			
Tuberculosis			
Ulcers			
Urinary Tract Problems			

A. Physical _____ WNL _____ Other (specify) _____

B. Mental and/or emotional _____ WNL _____ Other (specify) _____

C. Significant past history _____ WNL _____ Other (specify) _____

D. Any other disease or condition not mentioned on previous page:

E. Will this person wander off if not closely attended? _____ Yes _____ No

F. Will this person do harm to self, others or property without constant supervision?
_____ Yes _____ No

2. Special Requirements/Recommendations for Care:

*** Please complete medication list or attach a copy of medication list with MD signature on each page.**

A. Medications

Name	Dosage	Frequency	Route
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B. Allergies _____ ASA _____ PCN _____ Other (specify below)

C. Diet _____ Regular/DAT _____ Puree _____ Other: _____

_____ Special Needs: _____

_____ Food intolerances: _____

D. Therapy/Other Services Currently Receiving (Please give agency name and phone number) Needed in Day Care?

Physical Therapy _____

Speech Therapy _____

Occupational Therapy _____

In Home Care _____

(personal, nursing, home health agency, etc.)

E. Physical Restrictions/Limitations

No Restrictions Assistive Device Poor Endurance

Other (specify): _____

3. Is this person physically and mentally able to make an exit from the building in an emergency without assistance (i.e. without another person, wheelchair, walker, leg prosthesis or other device)?

Yes No

If assistance is needed, what type? _____

4. Is this person free of tuberculosis in a communicable form?

Yes No

Type of test(s): _____

Date of test(s): _____ Test results: _____

EXAMINATION FOR TUBERCULOSIS IS TO BE COMPLETED WITHIN 30 DAYS PRIOR TO ACCEPTANCE FOR ADMISSION TO ADULT DAY CARE OR WITHIN 30 DAYS PRIOR TO ADMISSION.

Inappropriate for test to be given Yes No

If Yes, why? _____

5. Is this person capable of administering his/her own medications?

Yes No

6. Permission is given to administer acetaminophen, 500 mg, one or two tablets PO for minor complaints?

Yes No

7. Verification of Above Information:

MD Signature _____ Date _____

Print/Type Physician Name _____

Address _____

Phone _____

Please Return To:

Generations Crossing 3765 Taylor Spring Lane Rockingham, VA 22801 fax (540) 434-8222

Revised 01/31/17