



1961 South Houston Levee Road  
Collierville, Tennessee 38017  
901-854-1200  
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### Physician's Form

(Note to Physician: The client and their caregiver below are completing an application for admission to Page Robbins Adult Day Center. We provide day services to adults with dementia and/or who are frail. Please complete this 3 page form and mail/fax it to our center or give to the primary caregiver. Thank you.)

#### General Information

Client Name \_\_\_\_\_  
(First) (Middle) (Last)

Street Address \_\_\_\_\_  
City and State \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male  Female

Responsible Party/  
Legal Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs B/P \_\_\_\_\_ Pulse \_\_\_\_\_

Drug/Allergies \_\_\_\_\_ Latex Allergy? \_\_\_\_\_

#### Identification and Background Information

Last Medical Assessment Date \_\_\_\_\_ by \_\_\_\_\_

Client is free of communicable diseases?  Yes  No

If there is a history of TB, client has been previously treated?  N/A  Yes  No

#### Bowel and Bladder:

Client has complete control of bowel and bladder  Yes  No

If No, Please Explain: \_\_\_\_\_

Client has one of the following:

- 1. External Catheter \_\_\_\_\_
- 2. In-dwelling Catheter \_\_\_\_\_
- 4. Ostomy (Please Specify) \_\_\_\_\_
- 6. Other \_\_\_\_\_

Client has been tested for a Urinary Tract Infection in the last 60 days Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Medication Prescribed: \_\_\_\_\_

**Disease Diagnosis** (Please check if yes)

**Heart/Circulation**

Arteriosclerotic Heart Disease   
Hypertension   
Hypotension

Congestive Heart Failure   
Transient Ischemic Attack (TIA)   
Other Cardiovascular Disease: \_\_\_\_\_

**Neurological**

Alzheimer's disease   
Other type of dementia   
Dementia, non-specific type   
Parkinson's disease   
CVA   
Other (Please specify) \_\_\_\_\_

Please note type: \_\_\_\_\_

**Pulmonary**

Emphysema   
Asthma   
COPD   
Other: (Please specify) \_\_\_\_\_

**Psychiatric/Mood**

Anxiety Disorder   
Depression   
Other: (Please specify): \_\_\_\_\_

**Vision**

Cataracts   
Glaucoma   
Uses Glasses

**Hearing**

Some Hearing Loss Right Ear  Left Ear   
Uses Hearing Aid Right Ear  Left Ear

**Other:**

Anemia   
Arthritis   
Cancer (Please Specify Type)   
Diabetes Mellitus   
Insulin Dependent   
Hypothyroidism   
Osteoporosis   
Seizure disorder   
Hiatal Hernia   
Other: \_\_\_\_\_

Type: \_\_\_\_\_

7. Past Surgical History: \_\_\_\_\_

8. Other Health Conditions: \_\_\_\_\_

**Existing Conditions:**

Constipation	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Dizziness/Vertigo	<input type="checkbox"/>	Edema	<input type="checkbox"/>
Hallucination/Delusions	<input type="checkbox"/>	other:	_____

**Ambulation:**

Independent

Uses assistive equipment

Please specify: \_\_\_\_\_

**Current Medications**

(Please include: Name, Dosage, Frequency and Reason for Medication)

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Non-Prescription Drugs: Please check the PRN medications that can be given at the Center.

\_\_\_ Acetaminophen 500 mg 1 – 2 tabs every 4 hours prn fever or discomfort.

\_\_\_ Ibuprofen 200 mg 2 tabs every 4 hours prn fever or discomfort.

\_\_\_ Antacid chewables 2 tablets every 4 hours GI discomfort.

\_\_\_ Antidiarrheal 1 tab of 2 mg, one time only prn for diarrhea.

\_\_\_\_\_  
Physician (Please sign **and** Print Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Address

\_\_\_\_\_  
Physician Phone Number