PAGE ROBBINS
ADULT DAY CENTER
1961 South Houston Levee Road
Collierville, Tennessee 38017
901-854-1200
Fax: 901-854-5726

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 **(Must be within last 6 months)**

Date _____Physician/Nurse Practitioner Completing Exam_____

Date of last TB skin test or chest x-ray? _____**(Must be within last 6 months)**

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 _____

Disease Diagnosis (Please check if yes)

Heart/Circulation

Arteriosclerotic Heart Disease ☐ Congestive Heart Failure ☐
Hypertension ☐ Transient Ischemic Attack (TIA) ☐
Hypotension ☐ Other Cardiovascular Disease:_____

Neurological

Alzheimer's disease ☐
Other type of dementia ☐ Please note type: _____
Dementia, non-specific type ☐
Parkinson's disease ☐
CVA ☐
Other (Please specify) _____

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) ☐ Type:_____
Diabetes Mellitus ☐
Insulin Dependent ☐
Hypothyroidism ☐
Osteoporosis ☐
Seizure disorder ☐
Hiatal Hernia ☐
Other: _____

7. Past Surgical History: _____

8. Other Health Conditions: _____

Existing Conditions:

Constipation	☐	Shortness of Breath	☐
Diarrhea	☐	Headaches	☐
Dizziness/Vertigo	☐	Edema	☐
Hallucination/Delusions	☐	other:_____	

Ambulation:

Independent ☐

Uses assistive equipment ☐

Please specify: _____

Current Medications

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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