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 ☐
Hypertension ☐
Hypotension ☐

Congestive Heart Failure ☐
Transient Ischemic Attack (TIA) ☐
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 ☐
Diarrhea ☐
Dizziness/Vertigo ☐
Hallucination/Delusions ☐
Shortness of Breath ☐
Headaches ☐
Edema ☐
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