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.)

MEDICAL RECORD RELEASE

To: ____

(Doctor, Hospital or Health Department)

I hereby authorize and request you to release to:

Page Robbins Adult Day Center — Phone: (901)854-1200
1961 S Houston Levee Road — Fax: (901)854-5726
Collierville, TN 38017

Name:____

(Patient)

Address: ____

(Street) (City/State) (Zip Code)

Medical Records and/or other information concerning my illness as requested on this document.

Sign Here: ______________________________________ Date: __________________________

Responsible Party

General Information

Client Name ____

(First) (Middle) (Last)

Date of Birth ____________________________ Male ☐ Female ☐

Responsible Party/
Legal Guardian ________________________________ Phone_____________________

Height ________ Weight _________lbs B/P ___________ Pulse__________

Drug/Allergies _____________________________________ Latex Allergy? ☐ Yes ☐ No

Identification and Background Information

Last Medical Assessment **(Must be within last 6 months)**

Date of exam_______________ Physician/Nurse Practitioner Completing Exam_____________________________

To your knowledge is the client free of communicable diseases? ☐ Yes ☐ No

Does the client have one of the following (please check any :
☐ External Catheter ☐ In-dwelling Catheter ☐ Ostomy (Please Specify) ☐ Other ___________________

Dietary Limitations:

☐ No added sugar ☐ No added salt ☐ Other: ______________________________

Disease Diagnosis (Please check if yes)

Heart/Circulation

Arteriosclerotic Heart Disease	☐	Congestive Heart Failure	☐
Hypertension	☐	Transient Ischemic Attack (TIA)	☐
Hypotension	☐	Pacemaker	☐
Atrial Fibrillation	☐	Other Cardiovascular Disease:________________	

Neurological

Alzheimer's disease	☐	CVA	☐
Parkinson's disease	☐	Parkinson's disease	☐
Dementia, non-specific type	☐		
Other type of dementia	☐	Please note type: ______________________	

Other (Please specify) ______________________________

Pulmonary

Emphysema	☐	COPD	☐
Asthma	☐		

Other: (Please specify) ______________________________

Psychiatric/Mood

Anxiety Disorder	☐	Depression	☐

Other: (Please specify): ______________________________

Vision		**Hearing**		
Cataracts	☐	Some Hearing Loss	Right Ear ☐	Left Ear ☐
Glaucoma	☐	Uses Hearing Aid	Right Ear ☐	Left Ear ☐
Uses Glasses	☐			

Other:

Anemia	☐	Arthritis	☐
Cancer (Please Specify Type)	☐	Type:______________________	
Diabetes Mellitus	☐	Insulin Dependent	☐
Hypothyroidism	☐	Osteoporosis	☐
Seizure disorder	☐	Hiatal Hernia	☐
Dialysis dependent	☐	Has Porta-cath (Which side: L or R)	☐

Other: ______________________________

7. Past Surgical History: ______________________________

8. Other Health Conditions: ______________________________

Existing Conditions:				**Ambulation:**	
Constipation	☐	Shortness of Breath	☐	Independent	☐
Diarrhea	☐	Headaches	☐	Uses assistive equipment	☐
Dizziness/Vertigo	☐	Edema	☐	Please specify: ____________________	
Hallucination/Delusions	☐	other:__________________			

Current Medications

Please include: Name, Dosage, Frequency and Reason for Medication. Please include PRN (as needed) medications and over the counter medications (including vitamins)

Name of Medication	Dosage	Time Given	Reason Given

Physician Signature ____________________ Date ____________________

Physician Name (Print) ____________________

Physician Address ____________________ Physician Phone Number ____________________