Saint Agnes Adult Day Service Center
1859 Harrison Boulevard
Valparaiso, Indiana 46385
Phone: (219)477-5433
Fax: (219)462-9553

To the examining physician:
A physical examination is required for participants of Saint Agnes Adult Day Service Center. Our purpose is to assess the client's ability to participate in our center activities as well as to be able to give better care if the client should become ill. We shall be glad to carry out any instructions you have for continued treatment or medical supervision while the client is in our care.

Doctor ____________________ Participant ____________________

Special Diet Order ____________________

Vital Signs BP ______ T ______ P ______ R ______ Ht ______ Wt ______

Primary Diagnosis ____________________

Secondary Diagnosis ____________________

Other ____________________

Please indicate any condition for which this client is receiving treatment

UTI ______ Diabetes ______ Hypertension ______ Coronary Artery Disease ______

Cerebral Vascular Disease ______ Peripheral Vascular Disease ______ Emphysema ______

Chronic Bronchitis ______ Asthma ______ Arthritis ______ Peptic Ulcer ______

Hiatal Hernia ______ Cancer (specify) ______________ Alzheimer's ______ COPD ______

Cirrhosis ______ Thyroid (hyper, hypo) ______ Glaucoma ______ Cataracts ______

Prostate ______ Parkinson's ______ Heart Disease (specify) ____________________

Dementia ______ Depression ______ Epilepsy ______ Multiple Sclerosis ______

Traumatic Head Injury (specify) ____________________

Mental Health Disorder (specify) ____________________

FREE FROM COMMUNICABLE DISEASE Yes ______ No ______

TB test given within three months of admission Date ______ Results ______

Chest X-ray (required if positive TB test – To be done within 6 months of admission) ________

Results ______

Pertinent past medical history ____________________

____

Allergies ____________________

May this patient take part in range of motion exercise activities? Yes ______ No ______

Any physical limitations? Yes ______ No ______

Please describe ____________________

Physician ______________________________ Patient ______________________________

Please list medications that your patient is taking.

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Medication Name ____

Time ______ Dosage ____

Please list additional medications on bottom.

Please add pertinent information. Is client compliant with medications? ______________________

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Please indicate which of the following may be given with supervision and following label instructions:

Tylenol______ Aspirin______ M.O.M.______ Dulcolax Supp. ______ O.T.C. Antacid ______

Fleets Enema prn. ______

I authorize periodic Nursing Physical Assessment of this client by

ADULT DAY CARE REGISTERED NURSE

Date ______ Physician's Signature ____

Physician's Address ____