Please complete and return to:

Main Line Adult Day Center

119 Radnor Street Bryn Mawr, PA 19010

Phone:610-527-4220 Fax: 610-527-6071

PHYSICIAN'S MEDICAL REPORT

(To be completed within 3 months prior to enrollment in adult day services and every year thereafter)

Date of Exam: _____

Patient Name: _____
Last First Middle

Address: _____
No. Street City State Zip

Past Surgical & Medical History: _____

_____

Current Diagnoses: _____

_____

Allergies/Sensitivities & Reaction: _____

_____

Mental/Emotional Status: _____

Physical Mobility: _____

Physical Findings/ROS: _____

TPR, BP: _____ Wt.: _____ Ht.: _____

EKG Date: _____ Result: _____

IMPORTANT
These two questions must be completed before patient may enroll in adult day services.

1. Is patient free from communicable disease or infection? Yes ____ No* ___

*If no, state disease or infection and what precautions are to be taken:

_____

2. PPD Test:

Date given: _____ Date read: _____ Result: Negative _____Positive*_____

Read by_____ Qualifications: _____

*If positive, chest x-ray within the past year is required.

X-Ray Date: _____ Result:_____

Chest x-ray only accepted with documented positive PPD reading.

Dietary Restrictions: _____

Current Immunizations: _____

Please continue on second page.

MEDICATIONS:

Name	Dosage	Time (If self-administered)	Side Effects

Please initial if you give permission to administer 500mg of Tylenol PRN for pain: _____
If another dose or type of pain medication is requested, please indicate**.** _____

List any other PRN medications that are approved for this patient which can be given at the center.

Name	Dosage	Under What Conditions (For example Anxiety, heart pain)

Impairments:	Unimpaired	Undetermined	Impaired/Sensory Aids
Aphasia	_____	_____	_____
Dysphasia	_____	_____	_____
Apraxia	_____	_____	_____
Dysarthria	_____	_____	_____
Hearing	_____	_____	_____
Vision	_____	_____	_____
Dementia	_____	_____	_____

Special Treatments or Care Required: _____

May this patient participate in the center's exercise program? ( ) Yes ( ) No
Please note any limitations: _____

*If PT or OT services are required, please submit request on separate Rx.

I certify that I have examined this person within the last three (3) months and have reviewed their health history. I find him/her able to participate in an adult day care program.

Physician's Name (Print): _____

Address: _____ Phone: _____

_____

Physician's Signature:_____ **Date:** _____