AiJalon, Inc. Adult Day Health

M E D I C A L   E X A M I N A T I O N

(TO BE COMPLETED BY PHYSICIAN)

DATE:______________________

NAME OF PATIENT:______________________________________ DATE OF BIRTH:____________________

ADDRESS:____

CITY/STATE/ZIP:____

HOME PHONE:_________________________________ CELL PHONE:____________________________

DIAGNOSIS OF ALZHEIMER'S DISEASE: ☐ YES ☐ NO DATE OF DIAGNOSIS:____________________

OTHER DIAGNOSES, MEDICAL PROBLEMS, OR IMPAIRMENTS?:_______________________________

____

____

PLEASE LIST ALL MEDICATIONS PATIENT IS RECEIVING (YOU WILL BE ASKED TO SIGN A CONSENT FORM FOR MEDICATION TO BE GIVEN DURING SERVICES HOURS):

MEDICATION	DOSAGE	FREQUENCY

ANY SPECIAL TREATMENTS OR CONSIDERATIONS?:_____________________________________

____

ANY DIETARY RESTRICTIONS?:____

____

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(TO BE COMPLETED BY PHYSICIAN – PAGE TWO)

ANY RESTRICTIONS ON PHYSICAL ACTIVITY?: ______________________________

____

PRESENT TPR: ______________ BP: ______________ ALLERGIES: ______________

TB TEST RESULTS OR CURRENT CHEST X-RAY DATE (PLEASE NOTE: CERTICIATION OF A NEGATIVE TB TEST OR CHEST X-RAY WITHIN PAST THREE (3) MONTHS IS REQUIRED: ______________________________

____

HAS PATIENT BEEN GIVEN MINI-MENTAL STATUS TEST? ☐ YES ☐ NO IF YES, TOTAL SCORE: ______________

DATE OF LAST EXAMINATION: ______________

ADDITIONAL COMMENTS AND RECOMMENDATIONS: ______________________________

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____

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____

____

PHYSICIAN NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

TELEPHONE: ______________________________

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