The person whose name appears below is an applicant for Adult Daycare Services at Successful Living Center, Inc. The purpose of the program is to help the person with dementia function at maximum capability and relieve the family member to work or have respite.

PHYSICIAN'S MEDICAL STATEMENT

Patient Name: _____ Date of Exam: _____

Length of time under your care: _____

Is there a diagnosis of Alzheimer Disease (or similar dementia)? ☐ Yes ☐ No

If Yes, when was the diagnosis made? _____

Is patient in early stages of disease? ☐ Yes ☐ No

Are there other medical problems? ☐ Yes ☐ No

If Yes, state the diagnosis and/ or impairment _____

_____

_____

_____

_____

Please list all current medications patient is receiving:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide additional medication page if needed.

Are there special treatments or considerations? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Are there dietary restrictions?

_____

_____

Are there restrictions on physical activity? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Allergies:

_____

_____

TB test result or current chest X-Ray and date: _____

(Please note that certification of a negative TB test or chest X-Ray within the past 3 months is required)

Has client been given Mini Mental Status Test or similar test? ☐ Yes ☐ No

If Yes, what were the results? _____

Do you have any additional comments and/ or recommendations?

_____

_____

Recommend for Adult Day Care at Successful Living Center? _____

Physician Name: _____ **(*please print*)**

Address: _____

City/ State/ Zip: _____ Phone & Fax No: _____

Physician Signature: _____ Date: _____