



2812 Old Lee Highway, Suite 210
Fairfax, VA 22031
Voice (703) 204-4664
Fax (703) 204-0509
www.alzheimersfdc.org

ALZHEIMER'S FAMILY DAY CENTER

REPORT OF PARTICIPANT PHYSICAL EXAMINATION--ADULT CARE PROGRAM

Examination is to be completed by or under the direction of a licensed physician either within 30 days prior to acceptance for admission or within 30 days prior to admission.

Date of Physical: _____

Name of Applicant: _____

Applicant Address: _____

Applicant Phone Number: _____

Applicant Date of Birth: _____

Physician Signature: _____

Date: _____

Print Physician's Name: _____

Physician's Address: _____

Physician's Phone Number: _____

Medical History and Current Status

Present Diagnoses and/or significant medical problems:

_____ Other

Disabilities: (Please Specify)

Relevant History

Physical History: _____

Mental History: _____

Fracture History: _____

Fall History: _____

Recent Surgery: _____

Recent Hospitalization: _____

Immunization History: _____

History of Drug Addiction or Excess Alcohol Intake: _____

Sensitivities to Medications: _____

Other Allergies (inc. animal): _____

Physical Examination: Blood Pressure: _____ Pulse: _____ Height: _____

Weight: _____ Height: _____ Blood Sugar: _____ U.A.: _____

Other: _____

Please see attached tuberculosis screening evaluation (**must be dated within 30 days prior to acceptance or admission**).

Recommendations for Care:

MEDICATIONS (Please add additional sheet if necessary)

Name of Medication	Dosage	Route	Frequency of Administration

If this person can take ASA, Tylenol or Ibuprofen for headache or minor aches and pains **please attach a PRN order for your preference.**

Is this person capable of administering his/her own medications without assistance? Yes _____ No _____

LIMITATIONS

Is this person physically and mentally capable of self-preservation by being able to respond in an emergency to make an exit from the building or to a safe refuge in an emergency without assistance of another person, even if he/she may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command?
Yes _____ No _____

Does this person have any restrictions/limitations on physical activities or program participation?
Yes _____ No: _____ If Yes indicate type of restrictions/limitations:

DIET

Regular No Concentrated Sweets Low Fat Ground Restrictions

Special diet or any food intolerances:

Nutritional Supplement: (Please Specify)

Fluid limitation (Please Specify)

Any food, medicine, animal or other allergies or intolerances?

THERAPY

List therapy (-ies), treatments or procedures the patient is undergoing or should receive and by whom:

Other:



2812 Old Lee Highway, Suite 210

Fairfax, VA 22031

Voice (703) 204-4664

Fax (703) 204-0509

www.alzheimersfdc.org

Report of Tuberculosis Screening

Date _____

Name _____

Date of Birth _____

To Whom It May Concern:

The above named individual has been evaluated by _____.

(Name of health dept/facility)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate modification for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____
(MD or Health Department Official)

Date _____

Address: _____

Phone _____



2812 Old Lee Highway
Suite 210
Fairfax, VA 22031
Voice (703) 204-4664
Fax (703) 204-0509
www.alzheimersfdc.org

Report of Tuberculosis Screening

Date _____

Name _____

Date of Birth _____

To Whom It May Concern:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

		Tuberculin Skin Test (PPD)	
Date Given	_____	Date Read	_____
Results:	_____ mm	_____ Negative	_____ Positive
Signature	_____	Date	_____
	(MD or Health Dept. Official)		
Address	_____	Phone	_____

		Chest X-ray Report – No Active Disease	
Date of chest x-ray	_____		
	_____	No evidence of active tuberculosis	
The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.			
Signature	_____	Date	_____
	(MD or Health Dept. Official)		
Address	_____	Phone	_____

		Chest X-Ray Report – Abnormal Report	
Date of chest x-ray	_____		
	_____	Chest X-ray abnormal, active tuberculosis to be ruled out	
Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.			
Signature	_____	Date	_____
	(MD or Health Dept. Official)		
Address	_____	Phone	_____