north shore senior center

NO

house of welcome adult day services specialized programs for persons with memory loss

MEDICAL EXAMINATION REPORT

Attention Physician: Your patient is planning to attend House of Welcome Adult Day Services (HOW) Day Program for people living with dementia. This form is a necessary part of their enrollment.

Please complete all sections, sign and return to HOW via fax to 847-242-6275 or email to <u>HOW@nssc.org</u>. If you have any questions, please call 847-242-6279.

NAME:	BIRTHDATE:
ADDRESS:	
CITY/STATE/ZIP:	
PHONE:	

Does the person have a diagnosis of mild cognitive impairment, Alzheimer's disease or other dementia?

(circle): YES

If yes, what is the diagnosis?

Date of diagnosis:

Please list all the applicant's physical health, mental health and substance use diagnoses and/or issues:

NAME:

Medication List

Please list all prescription medications, over-the-counter medications, and supplements.

Medication Name Dosage		Reason for Taking			
Can your patient receive over-the-counter	OTC medications at the program?	(circle):	YES	NO	
Are there special considerations or limitations	tions on physical activity?	(circle):	YES	NO	
<u>If yes, please explain:</u>					
<u></u>					
Does your patient have any dietary restric	otions	(circle):	YES	NO	
<u>lf yes, please explain:</u>					
Is the patient safe alone?		(circle):	YES	NO	
		<u></u> (on one).	120		
<u>Please explain:</u>					
Is the patient able to safely drive?		(circle):	YES	NO	
Please explain, including if you have disc	ussed this with the patient.				

NAME:

Does this patient have allergies?	(circle):	YES	NO
If yes, please explain			
Date of last tetanus toxoid			
Date of COVID 19 vaccination(s)			
Does the patient have a communicable disease?		YES	NO
If yes, please explain			
Please include last temperature, pulse rate and blood pressure			
Do you have any additional comments and/or recommendations?			
DATE OF LAST EXAM			
NAME OF PHYSICIAN			
PHYSICIAN SIGNATURE			
ADDRESS			
PHONE FAX			
EMAIL			