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 HOW@nssc.org. 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 NO

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 on physical activity? ***(circle)***: YES NO

If yes, please explain:

Does your patient have any dietary restrictions ***(circle)***: YES NO

If yes, please explain:

Is the patient safe alone? ***(circle)***: YES NO

Please explain:

Is the patient able to safely drive? ***(circle)***: YES NO

Please explain, including if you have discussed 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? *(circle)*: 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