



BRIGHTSIDE ADULT DAY SERVICE: PHYSICIAN'S FORM

Must be completed by family physician & returned to Brightside ADS.

Client Name		Date			
ALLERGIES		DOB		Age	
Height	Weight	Blood Pressure		Pulse	Respiration
MEDICATIONS (PLEASE LIST ALL)		DOSAGE		FREQUENCY	

Use back if more lines needed

PATIENT MEDICAL INFORMATION/DIAGNOSIS (CHECK ALL THAT APPLY)			
Dementia	<input type="checkbox"/> Dementia: Mild/Early stages	<input type="checkbox"/> Dementia: Mid-stage	<input type="checkbox"/> Dementia: Severe/late stage
Diabetes*	<input type="checkbox"/> Diabetes: Type I	<input type="checkbox"/> Diabetes: Type II	<input type="checkbox"/> Insulin <input type="checkbox"/> Oral <input type="checkbox"/> Diet controlled
Cardiac	<input type="checkbox"/> History of cardiac issues/surgery	<input type="checkbox"/> Cardiac: Pacemaker	<input type="checkbox"/> Cardiac: Defibrillator
Cancer	<input type="checkbox"/> Cancer: current (type)	<input type="checkbox"/> Cancer: history (type)	
Stroke/Seizures	<input type="checkbox"/> History of stroke CVA /TIA	<input type="checkbox"/> History of Seizures	<input type="checkbox"/> History of epilepsy
Incontinence	<input type="checkbox"/> Bladder	<input type="checkbox"/> Bowel	
Other medical	<input type="checkbox"/> Arthritis <input type="checkbox"/> Hypertension	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pulmonary Disease
Sensory	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Vision loss	<input type="checkbox"/> Speech issues
Ambulation	<input type="checkbox"/> Use cane <input type="checkbox"/> Use wheelchair	<input type="checkbox"/> Use walker	<input type="checkbox"/> Unable to transfer on own
Behavioral	<input type="checkbox"/> History of violent or aggressive behavior		
Other	Other medical concerns (list):		

DIETARY CONSIDERATIONS
*Diet: <input type="checkbox"/> Diabetic Diet <input type="checkbox"/> Low Sugar Diet <input type="checkbox"/> No concentrated sugars <input type="checkbox"/> Cardiac low fat/low salt <input type="checkbox"/> Mechanical soft
<input type="checkbox"/> Thickened Liquids <input type="checkbox"/> Other dietary concern (list):

HEALTH MAINTENANCE/IMMUNIZATIONS PLEASE NOTE: PATIENT MUST HAVE YEARLY TB TEST
TB Test date: _____ TB Test Result: _____
Flu shot date (if applicable): _____ Pneumonia shot date (if applicable): _____
Client is free of communicable diseases: <input type="checkbox"/> YES <input type="checkbox"/> NO
If no, please state disease or infection:

PHYSICIAN INFORMATION	PLEASE RETURN THIS COMPLETED FORM TO: BRIGHTSIDE ADULT DAY SERVICES, 1055 E. STATE STREET, ROCKFORD IL 61104 (FAX) 815.987.1934 (PHONE) 815.964.2433
Physician Name:	
Office address:	
Office phone number:	
Office fax number:	

I certify that I have examined this person within the last three months and have reviewed his/her health history. I find him/her appropriate and able to participate in Adult Day Services.

Physician signature	Physician (please print)
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