LIFESCAPE COMMUNITY SERVICES, INC.

# 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 |
|---|---|---|
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**WE REQUIRE DOCTOR'S ORDERS FOR OTC MEDICATIONS. PLEASE CHECK IF CLIENT MAY RECEIVE ACETAMINOPHEN ☐**

Use back if more lines needed list additional medications

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

**DIETARY CONSIDERATIONS**

***Diet:** ___Diabetic Diet ___Low Sugar Diet ___No concentrated sugars ___Cardiac low fat/low salt ___Mechanical soft

___Thickened Liquids ___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: ☐YES ☐NO

If no, please state disease or infection:

**PHYSICIAN INFORMATION**

Physician Name:

Office address:

Office phone number:

Office fax number:

**PLEASE RETURN THIS COMPLETED FORM TO: BRIGTHSIDE ADULT DAY SERVICE, 1055 E. STATE STREET, ROCKFORD IL 61104 (FAX) 815.987.1934 (PHONE) 815.964.2433**

***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.***

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|---|---|---|---|
| **Physician signature** | | **Physician (please print)** | |

UPDATED 4.1.10