Life Circle Adult Day Center
PHYSICIAN'S HEALTH ASSESSMENT FORM

Dear Provider:

Your patient has applied to attend the Life Circle Center for Healthy Aging in Santa Fe, NM, a State licensed adult day care center. The Center provides cognitive, social, and age- appropriate physical activities, as well as nutritious meals and snacks. Please complete this 4 page form and email to: Director@LifeCircleNM.org or give to the primary caregiver.

Patient Name: _____
(first) (middle) (last)
Street address _____
City & State _____

Date of Birth:_____ ❒ Male ❒Female

Responsible Party/Legal guardian: _____

Phone: _____

Height:	Weight:	Pulse:
Heart Rate:	Blood Pressure:	Respirations:

DRUG ALLERGIES: **Latex Allergy** ❒Yes ❒ No

Last Medical Assessment **(Must be within last 6 months)** Date_____

Physician/Nurse Practitioner Completing the Examination_____

TUBERCULOSIS SCREENING (must have completed one of these within last 6 months)

PPD Test	Date given:	Date read:	Results: ❒ Positive ❒ Negative
Chest X-Ray	Date given:	Date read:	Results: ❒Positive ❒Negative

If there is a history of TB, client has been previously treated? ❒ Yes ❒ No ❒ Not Applicable

Client is free of communicable diseases ❒ Yes ❒ No

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Disease Diagnosis (please check if yes)

Bowel and Bladder:

Client has complete control of bowel and bladder ❒ Yes ❒ No

If No, Please Explain: _____

Client has one of the following:

❒ External Catheter ❒ In-dwelling Catheter ❒ Ostomy (Please Specify)_____

Other _____

Heart/Circulation

❒ Arteriosclerotic Heart Disease
❒ Hypertension
❒ Hypotension
❒ Congestive Heart Failure
❒ Transient Ischemic Attack (TIA)
❒ Other Cardiovascular Disease:_____

Neurological

❒ Alzheimer's disease
❒ Other type of dementia Please note type: _____
❒ Dementia, non-specific type
❒ Parkinson's disease
❒ CVA
❒ Other (Please specify) _____

Pulmonary

❒ Emphysema
❒ Asthma
❒ COPD
❒ Other: (Please specify) _____

Psychiatric/Mood

❒ Anxiety Disorder
❒ Depression
❒ Other: (Please specify): _____

Vision

❒ Cataracts
❒ Glaucoma
❒ Uses Glasses

Hearing

Some Hearing Loss ❒ Right Ear ❒ Left Ear
Uses Hearing Aid ❒ Right Ear ❒ Left Ear

Other:

❒ Anemia ❒ Arthritis ❒ Cancer (Please Specify Type) Type:_____
❒ Diabetes Mellitus ❒ Insulin Dependent
❒ Hypothyroidism
❒ Osteoporosis
❒ Seizure disorder
❒ Hiatal Hernia
❒ Other: _____

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Existing Conditions:

- ❒ Constipation
- ❒ Diarrhea
- ❒ Dizziness/Vertigo
- ❒ Hallucination/Delusions other:_____
- ❒ Shortness of Breath
- ❒ Headaches
- ❒ Edema

Ambulation:

- ❒ Independent
- ❒ Uses assistive equipment

Please specify: _____

SIGNIFICANT MEDICAL HISTORY (past hospitalizations, recent surgeries, etc.):

Past Surgical History: _____

Other Health Conditions: _____

MEDICATIONS (dosage, frequency and indication):

Medication	Dosage	Frequency	Indication

MAY WE HAVE PRN ORDERS FOR: (Please Check off)

❒ Acetaminophen 500 mg. 1 or 2 tabs every 3-4 hrs PRN fever or discomfort

❒ Ibuprofen 200-400 Mg 2 tabs every 4 hrs PRN fever or discomfort

❒ Antacid Chewables 2 tablets every 4 hours for GI discomfort

❒ Antidiarrheal 1 tab of 2 mg, one only prn for diarrhea.

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DIET AND NUTRITION:

❒ Cardiac Diet (Low Sodium, Low Fat/Low Cholesterol)

❒ Diabetic/NCS

❒ Renal

❒ Regular

❒ Other: _____

MEDICATION AUTHORIZATION

❒ Yes ❒ No Patient is able to administer own medication safely

TRANSPORTATION

Although we endeavor to have participant's in transportation to and from the center for one hour or less, occasionally this is unavoidable. In order to provide regular and timely services, participants may be in vehicles over one hour. Are there any contraindications to this? ☐ Yes ☐No

Please list any restrictions or concerns (if applicable):

_____ Date: _____
Physician Signature

_____
Please Print Physician's full name :

License Number:_____

Phone:	Email:
Address:	