ADULT DAY of DUNWOODY
1 Dunwoody Park, Suite 123
Dunwoody, GA 30338
P:(770)551-2722 FAX:(866)857-8655

Physician's Evaluation Form or The Most Current H&P (preferred)

Name: ________________________________ Birthdate:__________________

Address:__________________________________ Phone#:_________________

____

Diagnosis, chronic illnesses and impairments:____

____

*BP:________________ *Pulse:__________________ *Weight:__________________

Medications Dosage Frequency

____

____

____

____

Can client administer own medication? Yes________No____ If no, please Comment____

Date of last Tetanus Toxoid (within last 10 years)_________________________________

Allergies (food, drug, or NKA):____

May applicant take 1-2 tablets of Tylenol q4 hrs/prn? Yes____________No________________

May applicant take Maalox 30 cc/Tums 1-2 q4 hrs/prn? Yes___________No________________

TB test result: Negative______Positive_________Date:_____________

(All prospective clients must have a current TB test before admission to the Adult Day of Dunwoody.)

Diet (Please ***circle*** *appropriate diet* for this client):

Regular Low Cholesterol Low Salt 1500 Calorie/Diabetic

SpecialConsiderations/Precautions/Comments:_________________________________

____

I hereby certify that the above day service plan is medically necessary and is approved by me:

____

Physician's Name (PRINT)

____ ______________________

Physician's Signature Date

____ ______________________

Physician's Address Phone Number

*Please complete all items to expedite initiation of services. Thank you.