ROYAL PALM ADULT DAY CARE CENTER

PHYSICIAN'S HEALTH ASSESSMENT & TUBERCULOSIS (TB) CLEARANCE

Participant Information

Participant Full Name: _____

Date of Birth: _____

Medical Assessment

Primary Diagnosis(es): _____

Secondary Diagnosis(es): _____

Relevant Medical History / Conditions:

_____

_____

_____

Allergies (if any): _____

Functional Status

Mobility (check all that apply):

☐ Independent ☐ Uses Cane ☐ Uses Walker ☐ Uses Wheelchair ☐ Requires Assistance

ADL Limitations (if any):

_____

_____

_____

Cognitive Status (if applicable):
☐ Alert / Oriented ☐ Mild Impairment ☐ Moderate Impairment ☐ Severe Impairment

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Medications

☐ See attached Medication List
☐ No current medications

Does the participant require **assistance with self-administration of medications**?
☐ Yes ☐ No
(If yes, assistance shall be provided only as ordered by the physician.)

Diet

Diet Type (check one):
☐ Regular ☐ Diabetic ☐ Cardiac ☐ Mechanical Soft ☐ Other: _____

Special Dietary Instructions (if any):

_____

Tuberculosis (TB) Screening

The participant has been screened and is **free from communicable tuberculosis** at the time of examination.

Date of TB Screening / Evaluation: _____

Clearance for Adult Day Care

Based on this assessment, the participant **is appropriate to receive Adult Day Care services**.

☐ Yes ☐ No

Health Care Practitioner Certification

Health Care Practitioner Name: _____
License Number: _____
Phone Number: _____

Signature: _____
Date: _____