**Welcome Home Adult Day Care and Young Adult Center**

**Medical Report**

**\*\*PLEASE HAVE PHYSICIAN COMPLETE THIS PAGE AND FAX TO 405-676-5509\*\***

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dietary Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medication & Dosage Frequency & Route of Admission**

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**Physical Activity Permitted: (Check type below)**

\_\_\_\_WALKS (on smooth pavement in groups of 3 w/ staff member or volunteer)

\_\_\_\_EXERCISE (stretch exercises while seated in chair, arms below shoulder level)

\_\_\_\_FIELD TRIPS (in a van, group of 10-12 clients w/ a volunteer and/or staff

Member trained in CPR & first aid. Minimal walking required)

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| **Physician’s Orders** | |
|  | Patient may attend adult day services |
|  | Patient is capable of self-administering medications independently |
|  | Patient requires appropriate adult day center staff to administer medications needed |
|  | Patient may take OTC medications sent to center by guardian(s) with supervision of RN, LPN, CMA, MAT, ETC. |
|  | Comments: |

Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_