445 A Willard Ave

Newington, CT 06111

ADMISSION MEDICAL INFORMATION AND ORDER FORM

Name: _____ DOB _____/_____/_____ Address: _____ Apt. _____ Town: _____ State _____ ZIP _____

DIAGNOSIS/ MEDICAL HISTORY: _____

_____

_____

_____ Recent hospitalizations (within one year) _____

_____

_____

Is this patient free of infectious diseases? PPD or Chest X-Ray _____

Date _____ Results _____

A Two-step PPD or chest x-ray required at time of admission

1st PPD at doctor's office (date) _____ (results may be read at Adult Day Center by Nursing staff)

2nd PPD at the Doctor's office (date) _____

Date of last Tetanus: _____ Pneumovax _____ Flu Vaccine _____

ALLERGIES: _____

DIET: _____ Restrictions or specification? _____

_____

Medications and/or Treatments: (please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PRN Medications: Tylenol (10 grains every 4 hours PRN); PPD; Fingerstick PRN; Influenza vaccine (1cc IM annually) In case of severe reaction: Epinephrine (1:1000 0.3cc IM)

_____ ACTIVITY: Restrictions, Limitations, Concerns: _____

_____

_____

_____

Any further comments: _____

_____

_____

I consider this person to be appropriate for and able to benefit from the Adult Day Health Center:

_____ Yes _____No

_____ Date ____/____/____ (Signature of Physician) (Printed name of Physician)

Address: _____ Phone # (_____) _____-_____

_____ Fax# (_____) _____-_____