Felician Adult Day Center
1333 Enfield Street
Enfield, CT 06082
860-745-2542 Phone
860-745-2542 Fax
info@felicianadultdaycare.org

ADMISSION PHYSICIAN FORM

____________________________________is a participant at the Felician Adult Day Center. We would be most appreciative if you would complete this form so that here at the Center we will be able to offer him/her the best of medical care.

BP________________ Pulse_________________

Known Allergies: (including food)

____

Present Health Problems/
Diagnoses:____
____

Dietary Restrictions:
____

Exercise Limitations:____

Present Medications: (Please indicate which will be given during Day Care)

Name	Dosage	Frequency
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________

Chronic Problems:

Hearing___________________________________ HearingAid?_________________________
Vision_____________________________________ Glasses?______________________________
Arthritis___________________________________Incontinence________________________
Pacemaker_________________________________ AnyProsthesis________________________

PHYSICIAN'S
SIGNATURE____**Date**__________________________________

Physician Form

(Filled out by the caretaker)

(Please Print)

Name of Physician ______________________________________Tel. __________________________

Address ____

City ______________________________________State ___________________Zip ______________

Risk Assessment form______________Date completed __________________

Other Medical Specialists

Name ____Tel. _________________________

Address ____

City ______________________________________State ___________________Zip ______________

Specialty ____

Special Visit yes_______ no_______

Required Visit yes______ no_______

Name ____Tel. __________________________

Address ____

City ______________________________________State _____________________Zip ____________

Specialty ____

Service Plan

Days of Care - Attendance: Mon ________Tue________Wed ________Thu ________Fri ________

MEDICATION AND EMERGENCY SERVICES

I am requesting assistance in administration of prescribed medication as follows to

_____________________________ while he/she is attending the Felician Adult Day Center.

Medication	**Time medication is to be given**
____	_____________________________________
____	_____________________________________
____	_____________________________________
____	_____________________________________

I understand that the personnel at the FELICIAN ADULT DAY CENTER will only assist with the medication, and that they are not responsible should the client refuse to take the medication.

Caregiver:____ **Date**:_______________