MEDICAL INFORMATION FORM
(Completed and Signed by Physician)

Name of Client_____ Date of Birth_____

Address_____ Zip Code_____

Telephone Number_____

Is there a diagnosis of Alzheimer's disease? Yes_____ No_____

If yes, when was the diagnosis made?_____

Are there other medical problems? Yes_____ No_____

If yes, state the diagnosis and/or impairment.

_____
_____
_____
_____

Please list all current medications patient is receiving.

Medication	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physicians Signature_____ Date_____

Please sign here to authorize our ADH Program Nurse to assist client with medication during service hours.

Are there any special treatments or considerations? Yes_____ No_____
If yes, describe:

_____
_____

Are there any dietary restrictions?

_____
_____

Are there any restrictions on physical activity? Yes_____ No_____

Recent TPR_____
BP_____

Allergies_____
_____

Please provide TB Test results or current chest x-ray and date.
_____
_____

Is client free of communicable diseases? Yes_____ No_____

Has client been given a Mini Mental Status Test? Yes_____ No_____

Total Score_____

Do you have any additional information comments and/or recommendations?

_____
_____
_____

Date of Last Exam_____

Name of Physician_____

Address_____
_____ Zip Code_____

Telephone Number_____

Please return by mail or fax to Liz Molina, RN, BSN, MA
Mailing Address: P.O. Box 866, Rome, GA 30162
Fax: 706-291-2921