Longview

Longview Social Adult Day Program
Pre-Admission Medical Evaluation

Statement of Purpose:
The Adult Day Community is to provide an environment that promotes social, physical, and cognitive stimulation. Through this stimulation we strive to improve the quality of life for adults over the age of fifty-five while providing respite care for their caregivers. The Adult Day Community brings adults from Ithaca and the surrounding areas to Longview for the day. They are welcomed participants in the Longview Community.

Name: _____

Address: _____
_____
_____

Date of Birth: _____/____/_____
Sex: _____
Exam Date: ____/____/_____

Section 1: Medical History

Primary Diagnosis:	Weight:
Recent Surgery (Type of procedure and date):	Blood Pressure:
Recent Acute Illness (Type and date):	Activity Restrictions:
Chronic Illness, Physical or Mental Limitations:	Weight Bearing (Full, partial, none):
Allergies/ Special Diet:	Required periodic intermittent nursing care, and/or medical examinations, doctor's visits, or skilled observation of symptoms:

Section II: Medications Needed (Type, frequency, and dosage):

_____

_____

_____

Section III: Observations of the Individual (circle Yes or No)

Yes / No :Individual capable of self-administration of required medication]
Yes / No :Ambulatory - without assistance
Yes / No :Ambulatory - with assistance
Yes / No :Chairfast – unable to transfer
Yes / No :Chairfast – able to transfer
Yes / No :Bedfast – unable to transfer
Yes / No :Bedfast – able to transfer
Yes / No :Incontinent (Describe)
Yes / No :Habituated or addicted to alcohol or another substance
Yes / No :If yes, is the individual a danger to his/herself or others?
Yes / No :Free of communicable disease

Section IV: Evaluation

In your opinion, do you feel this individual could benefit from adult social day care? **Yes/ No**

Section V: Tuberculin Test (Required within 30 days prior to admission unless medically contraindicated) __ Test is contraindicated

___ TST1:_____Date placed _____ Date read_____mm
___ TST2:_____Date placed _____ Date read_____mm
___ QuantiFERON-TB(QFT) _____Date placed_____Date read _____mm

Physician's Signature: _____ Date: _____
Please Print Name: _____ Phone #:_____