Coltrane L.I.F.E. Center, Inc.
Adult Day Services
321 Corban Ave. SE
Concord, NC 28025
(704) 788-1215
Fax (704) 788-1209

Medical Examination Report

Name ____ Date of Birth ____

Address ____

This form must be completed by the applicant's medical office personnel (not the applicant's family members).

The above-named person has applied for enrollment in Coltrane LIFE Center, Inc., adult day health services program. Your careful examination and written recommendations on this form will help to ensure that the applicant is provided appropriate care and services, will encourage safe participation in adult day services activities and will provide a current medical history in case of an emergency. Information reported on this is considered confidential and will be released only with the applicant's written authorization.

Most recent date seen by Doctor ____

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Does the applicant currently have or has had any of the following diseases or conditions? If so, please indicate whether or not the condition requires any special attention or restrict normal activities.

Current Disease or Chronic Condition	Yes	Special Attention Required	Restriction on Activities
Alzheimer's Disease/Dementia			
Anemia			
Asthma			
Blindness			
Cancer			
Cerebral Palsy			
Dentures/Partial Plate			
Diabetes			
Diarrhea			
Effects of Stroke, Paralysis			
Emphysema, Chronic Bronchitis			
Epilepsy/Seizures			
Fainting Spells			
Gastro-Intestinal Problems			
Heart Trouble (i.e. pacemaker)			
Hearing Problems/Hearing Aid			
High Blood Pressure			
HIV/AIDS			
Kidney Disease			
Mastectomy			
Mental Retardation			
Memory Impairment			
Phlebitis/Thrombophlebitis			
Skin Disorders			
Tuberculosis			
Ulcers			
Urinary Tract Problems			

Any other disease or condition not mentioned above:

____

Any allergies or reactions to any medications: ________________________________

Receiving any medical treatments? If so, explain. ______________________________

____

Does this person have any psychiatric problems? Yes ___ No ___. If yes, please comment on nature, severity and treatment needs: ____

____

Does this person require constant supervision to make sure he/she does not do harm to self, others or property?
Yes _____ No _____

Will this person wander off if not closely attended? Yes ____ No ____

Do you recommend any restrictions for medical reasons on physical activities such as walking, exercises, etc.?
Yes ____ No ____ If yes, please specify: _____________________________________

____

Please list all medications the person is now taking, with dosages and times medications are to be taken. (Print Clearly)

____
____
____
____
____

Please check all dietary restrictions that apply to this person.

1. No restrictions _____
2. Diabetic diet _____
3. Coumadin diet _____
4. Chopped Meats _____
5. Pureed Foods _____
6. Thickened Liquids _____
7. Food Allergies _____(please list)_____________________________
8. Other (please list) ______________________________________

Any other comments: ____

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I certify that I have today reviewed the health history and examined this person and find him/her physically able to participate in an adult day care activity program.

Signed ______________________________________ ______________________
Licensed Physician or Physician Assistant Date

Printed Name: _________________________________ Fax # __________________
Licensed Physician or Physician Assistant

Address ___________________________ City ________________ Telephone ______________

Please send completed form to:

Coltrane LIFE Center, Inc. 321 Corban Ave. SE Concord, NC 28025
704-788-1215 Fax 704-788-1209