SAINT ELIZABETH'S
ADULT DAY CARE CENTERS

PHYSICIAN & MEDICAL REVIEW

Please fax the requested information to:

_____ Arnold Center: 636-206-2849

_____Florissant Center: 314-334-4785

_____Ste. Genevieve Center: 314-664-1605

_____St. Louis Center:

SAINT ELIZABETH'S
ADULT DAY CARE CENTERS

PHYSICIAN & MEDICAL REVIEW

(To Be Completed by Physician)

Participant Name: _____ Date of Birth (DOB): _____

Date of Last Physical Exam: _____

Is the participant currently free from communicable or contagious diseases/infections? ☐ Yes ☐ No

Diagnoses:

_____

_____

Tuberculosis/TB Test Date: _____ Result: ☐ Negative ☐ Positive

Vital Signs:

Weight: _____ lbs. Blood Pressure: _____/_____ Pulse: _____

Mental Status / Behavior:

_____

Diet Type: ☐ Regular ☐ Mechanical Soft ☐ Pureed ☐ Cut Up

☐ Other:

_____

Please indicate which programs are recommended for the participant (check all that apply):

☐ Social Activities ☐ Therapeutic Work Activities ☐ Activities of Daily Living (ADL) Program

☐ Modified Exercise Program ☐ Recreational Activities

Allergies to food? ☐ Yes ☐ No Allergies to medications? ☐ Yes ☐ No Allergies to latex? ☐ Yes ☐ No

If yes, Explain:

_____

_____

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

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PHYSICIAN & MEDICAL REVIEW – CONT.

(To Be Completed by Physician)

Participant Name: _____ Date of Birth (DOB): _____

Code Status: ☐ Full Code ☐ DNR/Do Not Resuscitate

Can the participant self-administer medications? ☐ Yes ☐ No

Medications:

Medication Name	Dosage	Route (oral, topical, etc.)	Frequency / Directions	Indication for Use

Example Entry: PRN Acetaminophen – 500 mg – PO – 2 tabs every 6 hours – Pain/Fever

Physician's Printed Name: _____

Office Address: _____City_____ State_____ ZIP_____

Phone: _____ Fax: _____ Email: _____

Physician's Signature: _____ Date: _____

Information Release: _____Date: _____

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