YWCA Bethlehem
Adult Day Services Center
CLIENT PHYSICAL FORM
3893 Adler Place, Building B, Suite 180
Bethlehem PA 18017
Phone: 610-867-4669
Fax: 610-997-3786

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Form due back on/before: _____

Physicals MUST be completed yearly as per PA Dept. of Aging regulations and TB test bi-annually.

Client Name: _____
Address: _____
_____
Phone: _____
Email: _____
Responsible Party/POA: _____
Phone: _____

Physician: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

Birthdate: _____

To be completed by Physician (Please PRINT CLEARLY):

Primary Diagnosis: _____
_____

Secondary Diagnosis: _____
_____

Current Height: _____
Current Weight: _____
Current Blood Pressure: _____

Assistive Devices
Wheelchair : _____ *Cane:* _____
Walker: _____ *Sensory Aids:* _____
Other: _____

Medical History (Please check all applicable diagnosis):

_____ ***Alzheimer's/Dementia/Mental disabilities***
_____ ***Arthritis***
_____ ***Cancer***
_____ ***Cardiovascular Disease***
_____ ***Diabetes***
_____ ***Gastrointestinal Dysfunction***
_____ ***Gynecological Disorders***
_____ ***Prostate Disease***
_____ ***Hypertension***
_____ ***Kidney/Urinary dysfunction***
_____ ***Parkinson's***
_____ ***Respiratory Disease***
_____ ***Seizures***
_____ ***Stroke***
_____ ***Thyroid Dysfunctions***

Allergies

Food: _____ ***Yes*** _____ ***No*** ***If yes, describe:*** _____
_____

Drug: _____ ***Yes*** _____ ***No*** ***If yes, describe:*** _____
_____

Other: _____ ***Yes*** _____ ***No*** ***If yes, describe:*** _____
_____

Past Hospitalizations and/or Surgeries (Please include admission date and reasons):

_____

_____

_____

_____

_____

Physician Orders / Self-Administration Schedule:

At the Center, the client may have:

_____ 650 mg. Acetaminophen by mouth Q 4hrs PRN pain or fever.

_____ Antacid—1 tablet by mouth Q 4hrs PRN indigestion.

Other OTC Medication (Please describe):

_____

_____

Current Medications, Dosages and Frequency

(Please PRINT CLEARLY):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Can this individual participate in mild to moderate levels of exercise and program activities?

_____Yes _____No Any Restrictions? _____

_____

Please indicate any dietary restrictions here that are not allergy related:

_____ Low fat diet

_____ Low Sodium Diet

_____ Other: _____

_____ **Please check here if the individual has a diagnosis of *Intellectual Disabilities* that makes him/her eligible for ICF/ID level of care.**

By signing this physical form I attest that this individual is free from communicable diseases and/ or infections and I recommend they would benefit from adult day service level of care.

(Form MUST be signed by a Physician or Nurse Practitioner ONLY)

Physician also acknowledges if Client DOES have a communicable disease, they have written specific precautions.

Please Clearly Print Examining Physician's/Nurse Practitioner's Name _____

Physician's/Nurse Practitioner's Signature: _____ ***Date:*** _____

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Client TB Test Form

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YWCA Bethlehem Adult Day Services Center is licensed by the Pennsylvania Department of Aging and therefore must be in compliance with state regulations regarding participants being free of communicable diseases. A TB test must be taken prior to admission and then bi-annually. If a participant has a positive TB test, they MUST have a clear chest x-ray and results documented on this form as well.

Client Name: _____
Address: _____
_____
Phone: _____
Email: _____
Responsible Party/POA: _____
Phone: _____

Physician: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

Birthdate: _____

TB Test Due on or before: _____

Name/Product No./Lot: _____

Date Test Applied: _____ **By Whom:** _____ **Position:** _____

Date test Read: _____ **Negative** ** (*Place date on line of result*) **
_____ **Positive**

Result Read By Whom: _____ **Position:** _____

Chest x-ray results if positive PPD: ** (Place date on line of result) **
Date and result of chest x-ray: _____ *Negative*
_____ *Positive*

By signing this form I attest that this individual is free from communicable diseases and/or infections .
***** (Form MUST be signed by a Physician or Nurse Practitioner ONLY) *****

Please Clearly Print Examining Physician's/Nurse Practitioner's Name : _____

Physician's/Nurse Practitioner's Signature: _____ ***Date:*** _____