Northland
Adult Day Center LLC
1613 Swift Avenue, North Kansas City, MO 64116
(816) 844-3955–Phone (816) 844-3710-Fax

Physician's Pre-Admission Medical Assessment

This form must be filled out entirely. Failure to complete this form may result in your patient being denied care at our facility.

Name:	Date of Exam:
DOB:	Age:
	❑ Male ❑ Female
Principal and signature diagnosis:	List any current health problems:
Prognosis:	
Evidence of communicable disease? ❑ Yes ❑ No	Allergies:
Significant Medical History	
General:	Lungs:
HEENT:	Heart
Mouth:	Abdomen
Thorax:	Genitourinary:
Breast:	Musculoskeletal:
Lymphatic:	Rectal:
Diet: ❑ Regular ❑ Reduced Fat ❑ NAS ❑ NCS ❑ Other:	Weight:
Diabetes: ❑ Type1 ❑ Type 2 ❑ Not Applicable	Height:
❑ Use of EpiPen ❑ Use of Respiratory Equipment	Temperature
Participate in chair exercise program? ❑ Yes ❑ No	Blood pressure:
Restrictions: (allergies, textures, etc.)	Heart rate:
	History of seizures? ❑ Yes ❑ No
Tuberculosis Screening: (Optional)	If yes, date of last known seizure:
Last P.P.D. test:	
Last chest x-ray:	
Results:	

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Current Medications: (dosage and frequency) (May attach medication list)	
Medications	Medications
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
In the event of mild pain / temp >101, my patient may be given the following PRN:	May be repeated every four hours? ❑ Yes ❑ No Other:
Tylenol (two tablets):	Strength:
Advil (one tablet):	Strength:
Aspirin (5 gr, two tablets):	Strength:
Other:	Strength:
Is patient able to administer own medication? ❑ Yes ❑ No	
Mental Health Assessment	
❑ Dementia ❑ Alzheimer's ❑ Depression ❑ Agitation ❑ Anxiety ❑ Schizophrenia ❑ Bipolar	
Additional Comments:	
Past Medical History (please list any hospitalizations and/or surgeries):	
Special orders: All participants attending Northland Adult Day Center LLC are monitored by the nurse, who will notify you of any significant changes. Evaluation and treatment will be provided as appropriate for each participant unless contraindicated.	
I am ordering the following evaluation and treatments (Note frequency and duration):	
Physical Therapy	Occupational Therapy
Speech Therapy	
By signing, I approve of my patient attending Northland Adult Day Center program	
Physician's signature	Date:
Physician's name:	Phone number:
Physician's address:	Fax number: