Resources FOR SENIORS

**Total Life Center**
1110 Navaho Drive, Suite 400
Raleigh, NC 27609
Phone: (919) 872-7933 | Fax: (919) 872-6683

# APPLICANT MEDICAL EVALUATION FORM

The individual listed below desires participation in a Total Life Center Adult Day Service. Total Life Centers provide daytime supervision in a protective setting for ambulatory & semi-ambulatory dependent adults, especially those with memory loss & physical disabilities. At the Total Life Centers your patient will receive structured activities to maintain functional status, socialization & personal care. Each Total Life Center is certified by the NC Division of Aging & Adult Services.

In order to protect both the applicant & other participants, it is necessary that medical information is obtained on each participant attending the Adult Day Service. This information will also aide our staff in developing a personalized service plan to meet the participant's care needs.

**1. Patient's Name:** _____ **2. Date of Birth:** _____

**3. Most Recent Office Visit:** Did the patient visit your office today? ☐ Yes ☐ No

If NO, when was the most recent office visit? _____

**4. TB Test Results:** Date: _____ Results: ☐ Positive ☐ Negative Read by: _____

**5. Patient Vitals:** Blood Pressure: _____ Height: _____ Weight: _____

**6. Patient Diagnosis:** 1st: _____ 2nd: _____

3rd: _____ 4th: _____

**7. Physical Exam:** On review of the following areas, are there concerns or conditions that require intervention by Adult Day Service staff? If so please describe the condition and the intervention required. _____

| | Normal | Abnormal | | Normal | Abnormal | | Normal | Abnormal |
|---|---|---|---|---|---|---|---|---|
| a. Eyes | ☐ | ☐ | i. Chest | ☐ | ☐ | p. Pelvic | ☐ | ☐ |
| b. Ears | ☐ | ☐ | i. Breasts | ☐ | ☐ | **Female** | | |
| c. Nose | ☐ | ☐ | j. Lungs | ☐ | ☐ | q. Pelvic | ☐ | ☐ |
| d. Throat | ☐ | ☐ | k. Cardiovascular | ☐ | ☐ | r. Rectal | ☐ | ☐ |
| e. Mouth/Teeth | ☐ | ☐ | l. Abdomen | ☐ | ☐ | s. Bimanual Exam | ☐ | ☐ |
| f. Speech/Language | ☐ | ☐ | m. Genitalia | ☐ | ☐ | **Male** | | |
| g. Neck | ☐ | ☐ | n. Orthopedic | ☐ | ☐ | t. Rectal | ☐ | ☐ |
| h. Lymphatic System | ☐ | ☐ | o. Neurological | ☐ | ☐ | u. Prostate | ☐ | ☐ |

**8. Medical History:** Does the patient have any other Medical History that may be pertinent to our provision of care?

_____

**9. Communicable Disease:** To your knowledge does the patient currently have a chronic or communicable disease or other condition that could pose a health risk to others? ☐ Yes ☐ No If yes please explain: _____

_____

**10. Allergies:** Does the patient have any allergies, including drug allergies: ☐ Yes ☐ No

If yes please describe: _____

Revised: 2/10/09, 4/7/10, 6/14/16 JDM
Medical Form 2016

**11. Nutrition/Meal Modification:** Does your patient require a special diet or meal modification? ☐ Yes ☐ No

If yes, please describe : _____

_____

- Our lunch meal contains (on average) 800mg Sodium, 20g Fat, at least 700 Calories, at least 400mg Calcium & at least 21mg Protein. Do these nutritional criteria meet the nutritional requirements for the patient? ☐ Yes ☐ No

❖ **If No**, please complete the attached form from the Child & Adult Care Food Program which will serve as an order for the Total Life Centers to modify our regular menu to meet the diet restrictions you have prescribed.

**12. Mental Health Status:** Has the patient been diagnosed with a Mental Health related illness? ☐ Yes ☐ No

If yes please describe: _____

_____

**13. Mental Health Symptoms:** Has the patient exhibited any of the following symptoms?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol Abuse | ☐ Yes | ☐ No | Confused Thinking | ☐ Yes | ☐ No | Impaired Judgment | ☐ Yes | ☐ No |
| Drug Abuse | ☐ Yes | ☐ No | Orientation Problems | ☐ Yes | ☐ No | Loss of Appetite | ☐ Yes | ☐ No |
| Memory Loss | ☐ Yes | ☐ No | Insomnia | ☐ Yes | ☐ No | Overeating | ☐ Yes | ☐ No |
| Hallucinations | ☐ Yes | ☐ No | Anger/Hostility | ☐ Yes | ☐ No | Suicidal Ideations | ☐ Yes | ☐ No |
| Delusions | ☐ Yes | ☐ No | Feeling of Worthlessness | ☐ Yes | ☐ No | Self-Injurious Behaviors | ☐ Yes | ☐ No |
| Paranoia | ☐ Yes | ☐ No | Preoccupation w/ Health | ☐ Yes | ☐ No | Loss of Interest in Normal Activities | ☐ Yes | ☐ No |

Other: _____

**14. Medications:** Please list all medications the patient is currently taking, include the name, dosage, frequency & reason for the medication.

| Medicine | Dosage | Frequency | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**15. General Information:**

- Does the patient require constant supervision to prevent harm to self, others or property? ☐ Yes ☐ No
- Is the patient at risk for elopement unless provided with constant supervision? ☐ Yes ☐ No
- Can the patient do light exercises from a sitting position, such as leg lifts, arm lifts, etc.? ☐ Yes ☐ No

**Doctor's Signature:** _____ **Date:** _____

**Doctor's Name:** _____
(Please Print)

**Phone Number:** _____ **Fax:** _____ **Email:** _____

**Address:** _____
Street (City) (State) (Zip)

***Please feel free to contact us if you have any questions or other patients that might benefit from our program!**