Physician's Referral For Adult Medical Day Care

Maintaining Independence Adult Day Services, Inc.
11 Kimball Drive, Unit 110 Hooksett, NH 03106
Tel: 603-782-5447 Fax: 603-782-5665

****Include chart summary & most recent physical exam****

Participant's Name: ______________________________ DOB: ______________________________

Address: Phone #:

Physician's Name: ______________________________ Phone #: __________________________

Address: City, State, Zip:

Date of Last Flu Shot: ___________________________ Date of Pneumococcal Vacine: ____________________

Date of Last Mantoux (TB) Test and Results: ____

If Positive, how was TB treated: ____

Primary Diagnosis **must be a physical condition**

Diagnosis: ____

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Dietary needs: ____

Medications: (List on attached medication sheet)

Allergies (Meds, Food, Environamental): ____

B/P: _______________________ Weight: __________ Diet: ____

Brief Medical History - Treatment/Restrictions: ____

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Communicable Diseases: Yes: ☐ No: ☐

Ambulation:
Walks Independently☐ Walks with Assistance☐ Walks With Walker☐ Non-Ambulatory/Wheelchair☐

Memory Loss: Yes: ☐ No: ☐

Directives: ◯ DNR ◯ DNI ◯ DNH ◯ Full Code

Why adult day services are medically necessary: ____

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Adult medical day care is medically necessary for this patient to safely remain living in their home

Physician's Signature: X____ Date: X_________________

****Include chart summary & most recent physical exam****

FAX THIS FORM TO 603-782-5665 UPON COMPLETION