Peachtree Christian Health℠
A LIFE ENRICHMENT CENTER

INSTRUCTIONS

Participant/applicant may return Physician Certification Form, completed and signed by physician to:

Peachtree Christian Health, Inc.

Attention: Center Director

3430 Duluth Park Lane

Duluth, GA 30096

Main – 770-624-2727

Fax – 770-624-2594

The following information is confidential.

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ANNUAL PHYSICIAN CERTIFICATION FORM

Name: _____ Birth Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Diagnosis:_____

_____

Medications: (List all medications including those prescribed by other doctors) Dose and Medicine Schedule

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

General Appearance: Good _____ Fair _____ Poor _____ Height: _____ Weight: _____

Blood Pressure: R _____ L _____ Skin _____

Tremor: _____ Gait Station: _____

EENT: _____TB Test: Negative: ____ Positive: ____ Chest X-Ray Results: _____

Breast: _____ Date of X-Ray: _____

Heart: _____ X-Ray Report: _____

Lungs: _____ Abdomen: _____

GU & Rectal: _____ Pap: _____

Reflexes: _____ Varicosities: _____

Extrem: Color: _____ Edema: _____ Pulses: _____ Deformities: _____

Ambulation: Self: _____ With Assistance: _____ Wheelchair: _____ Walker: _____ Cane: _____

Laboratory Findings: Complete Urinalysis: _____ Blood Sugar: _____ CBC: _____

History of: Drug or Alcohol Abuse: _____

Mental Condition: Oriented: _____ Disoriented: _____ Constant: _____ Intermittently: _____

Ever dangerous to self or others: Yes: ___ No: ___ Specify: _____

Allergies: Yes: ____ No: ____ Specify: _____

Diet: Regular: ____ Special: ____ Specify: _____

Current Treatments/Therapy: _____

_____

Activities of Daily Living: Independent: _____ Needs Assistance: ____ Specify: _____

Recommendations, limitations, precautions, constant supervision (describe): _____

_____

What specific needs do you recommend be addressed for this person during adult day health care participation?

_____

I certify that I have made an examination of the above person and believe this person to be free from communicable disease, and that he/she may participate at Peachtree Christian Health, including geriatric exercises.

Physician Name: _____ Date Last Seen: _____

Physician Signature: _____ Date: _____

Mailing Address: _____ Telephone: _____