Return or fax form completed and signed by physician to:

770-624-2594

Attention: Center Director

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

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Allergies: Yes: ____ No: ____ Specify: ______________________

Diet: Regular: ____ Low Sodium: ____ Diabetic: _____ Other: ______________________

____

General Appearance: Good _______ Fair ______ Poor _______ Height: ________ Weight: _________

Blood Pressure: R ______ L ______ Skin ______________________

Tremor: ______________________ Gait Station: ______________________

TB Skin Test: Negative: ____ Positive: ____ Chest X-Ray Results: ________

Heart: ______________________ X-Ray Report: ______________________

Lungs: ______________________ Abdomen: ______________________

Ambulation: Self: ________ With Assistance: ________ Wheelchair: ________ Walker: ________ Cane: __________

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

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

Signs/symptoms of infectious disease likely to be transmitted to others: N o ___ Yes ___Specify: ______________

Current Treatments/Therapy: ______________________________

____

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: ______________