



# CLIENT MEDICAL REPORT

Please have this form completed by the client's physician office (M.D., P.A., or Nurse Practitioner) and returned to *More to Life* prior to enrollment and yearly thereafter. Please fax to: **(775) 358-1588**.

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of last Dr. visit: \_\_\_\_\_ Caregiver Phone Number: \_\_\_\_\_

Primary **Diagnosis**: \_\_\_\_\_

Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ SpO2: \_\_\_\_\_ Weight: \_\_\_\_\_

Please list all **client conditions** that might restrict activities or require special attention at an adult day center (physical, mental, emotional, immune system, contagious illness, allergies, special equipment, diet, etc.):

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→ As the Primary Care Physician, **I recommend** that this patient attend Adult Day Care for socialization, exercise, mental stimulation, and other health benefits at least \_\_\_\_\_ (please write a number 0 to 6) times per week.

Please attach a **list of all medicines** that the client is taking.

*More to Life* keeps the following **Over-the-counter medicines** on hand in the facility. Please indicate which, if any, of these medications may be given to the client as needed.

OTC / PRN Medication	Strength	Dose and Instructions	To be given for:	Dr. <u>initials</u> if OK
Advil (Ibuprofen tablets)	200 mg	1 tablet PO every 6 hours	Pain / Fever	
Aleve (Naproxen sodium tablets)	220 mg	1 tablet PO every 12 hours	Pain / Fever	
Loperamide HCl (Imodium)	2 mg	2 tablets PO (up to 4 tablets/24 hours)	Anti-diarrheal	
Milk of Magnesia (Magnesium Hydroxide)	Liquid	30 ml PO once daily	Constipation/ Irregularity / Heartburn / Indigestion	
Tylenol (Acetaminophen tablets)	325 mg	2 tablets PO every 6 hours	Pain / Fever	
TUMS E X (calcium carbonate chewables)	750 mg	2 tablets PO every 6 hours	Heartburn / Indigestion	

**I certify that I have reviewed the health history and examined this person and find him/her acceptable to participate in an adult day health care program.**

Signed: \_\_\_\_\_  
M.D., P.A., or Nurse Practitioner

Date: \_\_\_\_\_

Print: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_