COMMUNITY LONG TERM CARE
ADULT DAY HEALTH CARE FORM

FROM: TUCKER'S ADULT HEALTH DAY CARE ADHC

PARTICIPANT'S NAME: _____

SOCIAL SECURITY NUMBER -XXX-XX- _____- MEDICAID NUMBER, _____ DOB: _____

DIAGNOSIS: PRIMARY

(CURRENT) SECONDARY

MEDICAL HISTORY: _____

PHYSICAL EXAMINATION: T[| PI | R[| BP [|

LABORATORY DATA:

EENT:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTINAL:

GENITOURINARY:

MUSCULOSKELET AL:

SKIN:

ENDOCRINE:

ALLERGIES: _____

DIET:

SPECIAL CARE REQUIREMENTS: (List any daily activity limitations, special therapies or special care requirements):

Is the individual capable of self-administering their own medication(s)? [ ] Yes [ ] No

MEDICATIONS	DOSE/FREQ/ROUTE	MEDICATIONS	DOSE/ FREQ/ ROUTE

I ATTEST TO THE MEDICAL NECESSITY OF THE FOLLOWING SERVICES FOR THIS CLTC PROGRAM PARTICIPANT:

ADULT DAY HEALTH CARE ✓

ADULT DAY HEALTH CARE NURSING ____
(Must complete Form **122A.)**

SIGNATURE OF PRESCRIBER _____ DATE: _____

SIGNATURE OF ADHC STAFF Radiclani Clytus DATE: _____

DATE SENT: INITIALS: RC