Tallahassee Memorial HealthCare
Adult Day Care Services
2039 North Monroe St.
Phone: 850-531-0712

Healthcare Provider’s Statement
Form must be completed by healthcare facility even if records are attached. Thank you.

Client’s Name: ______________________  Date of Birth: ______________
Address: __________________________________________________________________

Current Diagnosis (Physical and /or Mental): ________________________________
________________________________________________________________________
________________________________________________________________________

Current Medication (including OTC)  Dosage  Frequency
____________________________________  _____  __________
____________________________________  _____  __________
____________________________________  _____  __________
____________________________________  _____  __________
____________________________________  _____  __________
____________________________________  _____  __________
(Attach additional pages if necessary)

Allergies: __________________________________________________________________
________________________________________________________________________

Activity Restrictions: __________________________________________________________________
________________________________________________________________________
Dietary Restrictions: ____________________________________________________________

Tuberculosis Test: _____ Yes ____No  Date of Test: ______________ Results: __________

If no, please explain reason ____________________________________________________

If unable to have TB test Chest X-ray is required:

Date of X-Ray: _______________ Results: __________________________

Is the patient free from signs and symptoms of other communicable diseases? ___Yes ___No

If no, please explain: __________________________________________________________

Other Comments: __________________________________________________________________________

______________________________________________________________________________________

Date of last Office Visit: ________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Healthcare Provider’s Name ___________________________ Date __________________________

Healthcare Provider’s Signature ____________________________

Reviewed by TMH ADC Program Coordinator ____________________________________________

***Upon completion please return to TMH Adult Day Care or fax to 850-531-9863***