ADULT CARE CENTER
OF ROANOKE VALLEY
Quality Daytime Care

2321 Roanoke Blvd.
Salem, VA 24153
Phone 540-981-2350 Fax 540-981-2353

PARTICIPANT MEDICAL REPORT

To be completed and signed by the primary care physician. Indicate that adult day care is appropriate for this person. ACCRV is licensed by the Virginia Department of Social Services and certified by Virginia Department Medical Assistance Services (Medicaid).

Patient Name: _____ SSN: _____

Address: _____Telephone: _____

D.O.B.: _____ Medicare #:_____ Medicaid #:_____

1. Diagnosis and/or Significant Medical Problems

Physical:

Mental and/or Emotional:

Pertinent Past History:

Current Medications: (Specify: Route, dosage and frequency, INCLUDING PRN's ASPIRIN, TYLENOL, ETC.)

2. Recommendations of Care

Diet: (Regular, Diabetic, Low Cholesterol, Low Sodium, Soft Foods, etc.)

Physical restrictions/limitations:

Allergies:

3. Administers his/her own medications? **YES ____ NO____**
4. Advanced directive on file? **YES_____ NO_____**
5. In an emergency, physically and mentally able to exit a building without human assistance? **YES_____ NO_____**
6. Tuberculosis in a communicable form? YES_____ NO_____
a. Test Date _____ Test Type: _____ Result: _____
(Note: Examination & TB Test is to be conducted within 30-days of enrollment)

Physician Name: _____ Date of exam: _____

Physician Signature: _____ Date: _____