COMMUNITY LONG TERM CARE
ADULT DAY HEALTH CARE FORM

FROM: _____ ADHC

PARTICIPANT'S NAME: _____

SOCIAL SECURITY NUMBER ___XXX – XX - _____ MEDICAID NUMBER_____ DOB: _____

DIAGNOSIS: PRIMARY

(CURRENT) SECONDARY

MEDICAL HISTORY: _____

PHYSICAL EXAMINATION: T [ ] P [ ] R [ ] BP [ ]

LABORATORY DATA:

EENT:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTINAL:

GENITOURINARY:

MUSCULOSKELETAL:

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 PHYSICIAN _____ DATE: _____

SIGNATURE OF ADHC STAFF DATE:

DATE SENT: INITIALS: