Golden Moments
Adult Day Health Spa

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Phone (413)727-3094
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Date: _____

Dear Dr. _____

Your patient, _____
DOB_____has requested to join our Adult Day Health Program_____ days a week. We require the following information, in order to facilitate entrance to our program.

_____

Medical History

Please note that *Massachusetts State Law* requires a history and physical, and TB test within 3 months of admission to this program

Any known allergies to food or medication? _____Y _____N If YES, please list._____

Please list medical conditions including communicable diseases:_____
_____
_____
_____

Limitations that we need to be aware of?
_____
_____

Are there any specific dietary restrictions?
_____

Any cognitive impairments or Diagnosis? Behavioral issues?
_____
_____
_____

Comments_____
_____

TB test is required prior to admission. Date: _____Results_____

Please send a list of current medications, and a copy of most recent physical.

Physician's signature_____Date:_____