

**To be completed by the client's primary health care provider**

Please fax this completed form and attachments to (608) 327-7043.

Client name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Does the client named above have any communicable disease, including Tuberculosis?

YES \_\_\_ NO \_\_\_

If yes, indicate which communicable disease: \_\_\_\_\_

**Please indicate the client's:**

- Allergies (drug, food and other): \_\_\_\_\_
- Diet: \_\_\_\_\_
- Code status (if Do Not Resuscitate (DNR), please attach DNR order): \_\_\_\_\_
- Restrictions that may limit their ability to participate in activities at the Adult Day Center:  
\_\_\_\_\_  
\_\_\_\_\_

**Please send the following items with this form:**

1. A list of all current diagnoses
2. Current immunization record
3. Proof of recent communicable disease screening: TB test results
4. A list of all prescribed medications including dosage, frequency and route
5. Advanced Directives, if applicable (including HCPOA, guardianship and/or DNR)

May the client self-administer medications? YES \_\_\_ NO \_\_\_

This form needs to be fully completed within 90 days prior to the client's enrollment date. TB test results will need to be completed 90 days prior to enrollment or within 7 days after the enrollment date.

Signature from the primary care provider certifies that all information above in this health statement is correct.

PCP name (please print) \_\_\_\_\_

PCP Signature \_\_\_\_\_

Date \_\_\_\_\_