SHARE YOUR CARE
ADULT DAY SERVICES

PERSON SERVED:	SOCIAL SECURITY #:	DATE OF BIRTH:
I hereby give my permission for this physician to provide the following information to Share Your Care, Inc. ___________________________________ Patient's Signature	____ Authorized Legal Representative's Signature	
Physician:	Address:	Phone Number:
Dear Physician: We would appreciate your assistance in evaluating the health and functional status of your patient. This information is important for the purpose of designing therapeutic day services appropriate to this person's abilities and situation. Please feel free to include any assessments or other information which you deem pertinent. If you are aware of other physicians who treat this patient, please indicate this in the space provided. Thank you for your time.		
Is there another physician who treats this patient? ___Yes ___No	Name & Telephone # of other physicians:	

Health Information:

TB Test or Chest X-Ray Within One Year Evidencing Free of Active TB:-Yes -No	Does the Patient have active: _Hepatitis A _Hepatitis B _Hepatitis C Does the Patient have other communicable/contagious/notifiable diseases: Yes -No If Yes, specify:	
Primary Diagnosis:	Secondary Diagnosis:	Behavioral Health Diagnosis:
Vaccines (Date): Tetanus ______ Influenza ______ Pneumonococal ______ Other ______		Date Last Seen By Physician: __________
Rx and Food Allergies:		
Dietary Instructions for Day Program (Check All That Apply): Regular ____ No Concentrated Sweets ____ No Added Salt____ **{Modified ____ (*Please Check All That Apply for Modified*) Soft____ Chopped (*Specify Size, ex; Quarter, dime, etc.*)________________** **Ground (1/4 inch Pieces)____ Minced (1/8 inch Pieces) ____ Pureed____ }** Foods to Avoid: ____		
Other Dietary Considerations:		
Orientation: Patient is oriented to: Person __ Place __ Time __ Date __ Circumstances __		
Presenting Problem(s): Organic Disorder (as Dementia): MMSE Score Personality Change Short-term Memory Deficit		
Schizophrenia __ Depression Disorder __ Anxiety Disorder __ Other __________________________________		

Medications:

Psychotropic Name:	Dosage:	Frequency:	Target Symptoms:
Other Medications Name:	Dosage:	Frequency:	Target Symptoms:
Is this patient able to self-medicate? Yes __ With Assistance __ No Comments:			
If patient receives psychotropic meds., the physician certifies the patient and/or caregiver has been educated regarding contraindications, side or unusual effects, Psychotropic meds. are only used as an adjunct to Mental Health Services. Patient or their legal representative was involved with all medication/health care decisions. Physician's Initials _______			
This patient is at risk for: __ Abuse or Exploitation __ Neglect (including self-neglect) __ Pre-Mature Institutionalization I recommend Adult Day Care Services: __YES __NO			
Physician's Signature:		Date:	

SHARE YOUR CARE, INC.
BOX 35101
ALBUQUERQUE, NM 87176

SYC Staff Please Check One:

___PONDEROSA SITE:	TELEPHONE # (505) 881-8982	FAX # (505) 872-0392
___CITY SITES:	TELEPHONE # (505) 298-1700	FAX # (505) 298-1900
___RIO RANCHO SITE:	TELEPHONE # (505) 897-9025	FAX # (505) 897-1768