UCMJ Adult Day Activity Center

Confidential Physician's Report & Medical Release Form
6089 Apple Tree Drive, Memphis, TN 38117 | (901) 612-1400 | ucmjadcac@gmail.com

Section 1 – Applicant Information
Full Name: _____
Date of Birth: _____ Age: _____ Gender: _____
Address: _____
Phone Number: _____

Section 2 – Physician Information
Physician's Name: _____
Practice/Clinic: _____
Address: _____
Phone: _____ Fax/Email: _____

Section 3 – Dietary Limitations
■ No Added Sugar ■ No Added Salt ■ Other: _____

Section 4 – Disease Diagnosis (Check all that apply)
Heart / Circulation
■ Arteriosclerotic Heart Disease
■ Congestive Heart Failure
■ Hypertension
■ Transient Ischemic Attack (TIA)
■ Hypotension
■ Pacemaker
■ Atrial Fibrillation
■ Other Cardiovascular: _____

Neurological
■ Alzheimer's Disease
■ CVA (Stroke)
■ Parkinson's Disease
■ Dementia (non-specific)
■ Other Dementia: _____
■ Other: _____

Pulmonary
■ Emphysema
■ COPD
■ Asthma
■ Other: _____

Psychiatric / Mood
■ Anxiety Disorder
■ Depression
■ Other: _____

Vision
■ Cataracts
■ Glaucoma
■ Uses Glasses

■ Other: _____

Hearing
■ Some Hearing Loss (Right/Left)
■ Uses Hearing Aid (Right/Left)
■ Other: _____

Other Conditions
■ Anemia
■ Arthritis
■ Cancer (Type: _____)
■ Diabetes Mellitus (Insulin Dependent/Not)
■ Hypothyroidism
■ Osteoporosis
■ Seizure Disorder
■ Hiatal Hernia
■ Dialysis Dependent
■ Porta-cath (Left/Right)
■ Other: _____

Section 5 – Past Surgical History

_____

Section 6 – Other Health & Existing Conditions
Constipation, Diarrhea, Dizziness/Vertigo, Shortness of Breath,
Headaches, Edema, Hallucinations/Delusions, Other: _____
Ambulation: ■ Independent ■ Uses Assistive Equipment (specify: _____)

Section 7 – Current Medications

Name of Medication	Dosage	Time Given	Reason for Medication

Section 8 – Physician's Recommendation
Is the applicant medically stable to participate in the UCMJ Adult Day Activity Center program?
■ Yes, without restrictions ■ Yes, with restrictions ■ No

Physician Signature: _____
Date: _____
Physician Name (Print): _____

Medical Release Authorization
I authorize my physician and their staff to release medical information regarding my health and care to the UCMJ Adult Day Activity Center at 6089 Apple Tree Drive, Memphis, TN 38117, (901) 612-1400. This release includes, but is not limited to: medical history, medications, allergies, treatment plans, and recommendations necessary for participation in the program. I understand this information will be kept confidential and used solely to ensure my health, safety, and well-being while enrolled in the program.

Applicant/Guardian Signature: _____
Date: _____
Witness (if required): _____