The UCMJ Adult Day Activity Center
6089 Apple Tree Drive
Memphis, TN 38117
ucmjadac@gmail.com

TREATMENT FORM

Name _____ Date of Birth _____

Address _____

_____

Gender _____ Marital Status _____ Age as of admit date _____ Eye Color _____

Responsible Party/Caregiver _____ Home Phone _____

Relationship to client _____ Work Phone _____

Home Address _____ Caregiver's Place of Work _____

Cell Phone _____

2nd Name for Emergency _____ Home Phone _____

Address _____ Work Phone _____

Cell Phone _____

Physician _____ Phone _____

Hospital Preference _____ Allergies _____

DNR (Do Not Resuscitate Order) or POST provided to the Center**:** ( ) Yes *Date provided _____ ( ) No

Diagnosis: _____

_____

Please signature below if in agreement.

The Responsible Party have understood and agreed that The UCMJ Adult Day Activity Center cannot be responsible for routine medical maintenance, care or consultation and that all arrangements for any medical problem or special physical or medical needs shall be the sole responsibility of the caregiver, guardian or responsible party. The above responsible party provides permission to The UCMJ Adult Day Care Activity Center to provide this Emergency Treatment Form, a DNR or POST (if available), and medical form to emergency personnel in case of an emergency.

_____ _____

Responsible Party Date completed