
Greater Aiken Chamber of Commerce's

Small Business of the Year

690 Medical Park Drive

P) 803-226-0355 F) 803-226-0366

Physician's Examination

Name: _____ Birthdate: _____

Cognitive diagnosis: _____

Current health concerns: _____

Medication Allergies: _____

Food Allergies: _____

We serve a REGULAR DIET. Should patient provide their own meal to meet dietary restrictions? Yes/No

Does patient:

Fall frequently? Yes/No

Have limitations of activity? Yes/No _____

Have Communicable Disease(s)? Yes/No _____

Have uncontrolled Adverse Behavior(s)? Yes/No

*If Yes, please explain* _____

Currently exit-seek or attempt elopement? Yes/No

Transfer with assist of one person? Yes/No

Have frequent bowel incontinence? Yes/No

Patient may:

Receive medications per orders with staff assistance? Yes/No

Receive Annual Flu Vaccine? Yes/No

Receive basic first aid treatment? Yes/No

Be evaluated/treated as indicated for Home Health PT/OT/ST/Nsg Yes/No

Receive hospice evaluation with family's consent? Yes/No

# PLEASE PROVIDE A CURRENT MEDICATION LIST

My patient is appropriate to participate in a social day program and does not require 24 hour skilled nursing services.

_____

Physician's Signature Date