The Oaks Adult Day Program
2500 S. Main Street
Ann Arbor, MI  48103
Phone: (734) 662-4001
Fax:     (734) 926-4649

Dr. _______________________________________________ Date: ____________

Phone: _______________________________ Fax: ________________________________

I hereby give the above named physician permission to release information to The Oaks Adult Day program as part of the intake process.

**Participant Name: _________________________________________________________**

**Date of Birth: _______/________/__________**

**Signature: ___________________________________________ Date: ____________**

**Relationship: _________________________________________**

Please complete this form in its entirety and fax back to The Oaks Adult Day program. You may attach pertinent documents such as medication list, hospitalizations, medical history. This form must be returned before the participant is able to begin attending the program.

Sincerely,

Lisa C. Gdaniec, LLMSW
Site Manager ~ The Oaks Adult Day

CAREGIVER STOP HERE—DO NOT FILL OUT BELOW THIS LINE

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**Date of Last Examination (must be within past 6 months):**
__________/_________/_________

**Diagnosis of Dementia (ie. Alzheimer's Disease, vascular, Frontal Lobe, Lewey Bodies)?**
Yes ____        No ____    If yes, please list type: _________________________________________

**Physical Health history: ____________________________________________________________**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**Mental Health history:** ________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Substance Abuse history:** ______________________________________________________

______________________________________________________________________________

**Is free of communicable disease?** Yes ____ No ____ If no, please describe: _____________

______________________________________________________________________________

**Dietary restrictions (ie. Diabetic, low fat, chocking risk, etc.)?** Yes _____ No _____

If yes, please explain: __________________________________________________________

______________________________________________________________________________

**Hospitalizations during last 5 years (year and reason):** Please attach

**Current Medications:** Please attach printout of current medications. If none are taken, please write none. _________________________

**Requires supervision?** Yes _____ No _____

Do you feel that your patient will be able to physically participate in The Oaks Adult Day Services program of recreational and therapeutic activities (i.e. chair exercises, crafts, ball/bean bag toss, table games, cognitive stimulation, etc.)? Yes _____ No _____

**Any additional comments:** ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Physician's Signature:** ___________________________________ **Date:** __________

Please return by fax or mail. Thank you for your assistance.