Riverwalk Adult Day Services
305 W. Jackson Ave
Naperville, Il 60540
Email:
RiverwalkAdultcare@att.net
Fax: 630-357-3260

RIVERWALK
ADULT DAY SERVICES

Please mail, email, or fax this form back so this individual may begin attendance in our program.

Physician's Report - (Please print or type)

Patient: _____ Report Date: _____

Age: _____ Birthdate: _____ Last Office Visit: _____

Date of Most Recent Chest X-Ray: _____ Results: _____
OR
Date of Most Recent TB Test: _____ Results: _____

Blood Pressure: _____ Height: _____ Weight: _____

Date Flu shot given: _____

Date Covid shots given 1st dose: _____ 2nd dose: _____ Booster: _____ Type: _____

Current Diagnosis: _____

_____

Medical History: _____

_____

General Physical Condition:	☐Good	☐Fair	☐Poor	
Vision:	☐Good	☐Fair	☐Poor	
Hearing:	☐Good	☐Fair	☐Poor	
Speech:	☐Good	☐Fair	☐Poor	
Ambulation:	☐Good	☐Fair	☐Poor	
Wears Dentures:	☐Yes	☐No		
Continence of bowel:	☐Yes	☐No	Wears Depends?	☐Yes ☐No
Continence of bladder:	☐Yes	☐No		

Is able to participant in Chair Exercise: ☐Yes ☐No Is able to go on a short walk: ☐Yes ☐No

Restrictions: _____

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Physician's Report – (Cont.)

Special Diet: _____

Allergies: _____

Does this patient have advance directives in place? ☐ Yes ☐ No

Please list all medications and over-the-counter medicines taken in a 24-hour period:(or send a medication list)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor's Signature: _____ Print Doctor's Name: _____

Telephone #: _____ Fax #: _____

Patient Name: _____ Date: _____