

TO BE COMPLETED BY EXAMINER:

- Additional accommodations (see back).
- No additional accommodations.

If required accommodations are met, this person may return to day/employment program participation on:

DATE



NEXT APPOINTMENT

Date: _____

Time: _____

MEDICAL APPOINTMENT RECORD

I. All of the information on Part I must be completed prior to the appointment. Please write clearly in blue or black ink.

A. Name _____

B. Type of Appointment _____

C. Date of Appointment _____ Time: _____

D. Name of Practitioner/Clinic _____

Address/Phone # _____

E. Reason for Services _____

F. Current Allergies, Medications and Dosages – Refer to current physician’s medication order form (PMOF).

ALWAYS TAKE THE PERSON’S INSURANCE INFORMATION TO EVERY APPOINTMENT.
MAKE SURE THE EXPIRATION DATE IS CURRENT.

II. This section must be completed in its entirety and signed by the healthcare professional seeing the person.

A. Results of Exam/Diagnosis of Current Medical/Psychiatric Problems _____

B. Additional Caregiver Instructions _____

C. Signature & Title of Examiner _____

D. Telephone Number of Examiner _____

E. Caregiver with Person Served at Time of Appointment _____

Staff is not to sign any papers indicating they are the representative for the person served receiving medical services.

Physical limitations check-list on back →

Physical Limitations Check-List

Chimes provides day programs and a vocational program for persons who are developmentally disabled. At all facilities we have Nursing and a Medical Suite on site. Medications are dispensed per doctor's orders. Within the combination of Chimes sites, we can accommodate a wide variety of physical limitations.

1. Based on this person's **current injury/illness/condition**, what **additional limitations** will need accommodation for him/her to participate in a day/vocational program? Please check all that apply.

(I.A.) **No limitation due to this person's current injury/illness/condition.**

(I.B.) **This person must NOT:**

- Stand
- Stand for extended periods (2-4 hours)
- Lift 10 pounds or less
- Lift more than 10 pounds
- Carry items 10 pounds or less
- Carry items more than 10 pounds
- Bend at the waist
- Bend at the knees
- Walk more than 10 steps at a time
- Climb stairs
- Exert upper body range of motion
- Exert lower body range of motion
- Independently perform personal care, transferring and mobility
- Participate in community outings
- Sit for more than 1 hour at a time
- Sit for extended periods (4-6 hours at a time)
- Wear closed toe shoe(s)
- Be required to be aware of environmental stimuli

(II) **This person must use the following new medical equipment:** _____

(III) **Any additional information:** _____

Signature & Title

Date