

DirectCare Community Based Services, LLC

Medical Clearance Admission Statement

Client Name: _____ Date of birth: _____

Physician/Nurse Name: _____ Office Phone Number _____

Height: _____ Weight: _____ Last exam: _____

Allergies and reactions: _____

Immunizations up to date: yes / no

Next immunizations needed and when: _____

General Health Status: _____

Current medical or communicable disease concerns: _____

Current treatment and/or follow up care required or next well visit exam recommendation: _____

Must check 1 option:

I am attaching an order form with medication and doctor orders

I am not attaching any MD orders

Must check 1 option:

Client has no active medical issues and is medically cleared for residential placement

Client's current medical condition of _____ can be

safely and appropriately maintained in a residential care facility setting with the following

treatment and/or follow-up care: _____

Client is not medically suitable for a residential care facility placement this time

Nurse/Physician Signature

Date

DirectCare Management Signature

Date