



# Advocate Medical Group

GENERAL INFORMATION || ADULT DOWN SYNDROME CENTER || ADVOCATE LUTHERAN GENERAL HOSPITAL

Patient Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**Name of person responsible for medical appointments**

Name \_\_\_\_\_ Daytime phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Fax Number \_\_\_\_\_

Two to three weeks after a complete physical evaluation at the Adult Down Syndrome Center a written summary of the visit is prepared to include the following: Active problems, past medical history, immunizations, current medications, allergies, family history, review of systems, physical exam, psychosocial evaluation, nutritional evaluation and assessment & plan.

The patient’s signature or guardian’s signature below authorizes us to send copies of this summary report and/or test results to the legal guardian and to the residential agency (if applicable). Additional copies of the report may be distributed by the guardian as necessary.

Signature of patient (if self guardian) or guardian:

\_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY/LEGAL GUARDIAN**

Send report/results: Yes  No

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Fax number \_\_\_\_\_

**SERVICE PROVIDER/GROUP HOME**

Send report/results: Yes  No

Agency \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Fax number \_\_\_\_\_

Nursing office contact information:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**PRIMARY DOCTOR**

Send report/results: Yes  No

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ Fax number \_\_\_\_\_