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 _____