Adult Medical Day Care - Daily Care Connection	
Name of Participant:	Date of Birth:
Who did you speak with?	Date and Time of Contact:

Questions		
1. Do you have enough food and fluids?	Yes ◯	No ◯
2. Are you taking all of the medicines your doctor told you to take?	Yes ◯	No ◯
3. Are there any essential supplies that you need?	Yes ◯	No ◯
4. Remind the participant to contact their doctor if they don't feel well. If the participant has any significant change in their health or reports new medical complaints, then the caller shall notify the center's nurse.	Yes ◯	No ◯

Comments (use the back of this page for additional comments):	
Signature of Employee:	Print Name:
By signing above, I hereby certify, under penalty of perjury, that the foregoing information is true and correct. This record will be maintained for at least 5 years from the date of creation and shall immediately be made available to the Maryland Department of Health upon request.	