ADULT DAY HEALTH

Medical Examination Report

Name____ **DOB**____________________

Most Recent Date Seen by Doctor prior to this visit? ___________________

The above named person has applied for, or is enrolled in our adult day health care program. Please completed this form in detail. Your careful examination and written recommendations will help to ensure that the applicant is provided appropriate care and services and will provide a current medical history in case of emergency. Information reported on this form is considered confidential and will be released only with the applicant's written authorization.

1. Does the applicant have any of the following diseases or conditions? If so, please indicate whether or not the condition requires any special attention or restricts normal activities.

CURRENT DISEASE/CHRONIC CONDITION	YES	Special Attention Required?	Restriction on Activities
Anemia			
Arthritis			
Asthma			
Blindness			
Cerebral Palsy			
Dementia – List type: Vascular, Alzheimer's, Lewy Body, other?			
Diabetes			
Diarrhea			
Emphysema			
Epilepsy			
Fainting Spells			
Gastro-Intestinal Prob.			
Heart Trouble			
Hearing Problems			
High Blood Pressure			
Kidney Disease			
Down's Syndrome			
Skin Disorders			
Stroke /Paralysis			
Tuberculosis			*Test Results?
Urinary Tract Problems			
Mobility Issues			
Intellectual Disability			
Other?			
Other?			

2. List all allergies or reactions to medications? ____

____

3. Is client receiving any on-going medical treatments? If so, please explain. ______________________

____

____

4. Does this person have any psychiatric problems? ____ NO ____YES – if yes, please provide information re: type, severity, and treatment needs:

____

____

5. Does this person require constant supervision to make sure he/she does not do harm to self, others, or property? _____NO ____YES

6. Is this person at risk for wandering? _____NO ____YES

7. Does this person require any restrictions on physical activities such as walking, chair exercises, etc, - based on a medical condition? _____NO ____YES – If yes, please specify:

____

____

8. Please list all medications the person is now taking, or attach a separate sheet, listing dosages and times medications are to be taken.

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

9. Special Diet? _____NO ____YES – If yes, please describe or attach a copy:

10. Any other comments?____

____

I certify that I have examined this person & their health history and find him/her able to participate in an adult day health care program.

Date: Signature____

Printed Name____
Licensed Physician or P.A.

Office Address/Phone/Fax:

AUTHORIZATION TO ADMINISTER MEDICATIONS and STANDING ORDERS FOR

Durham Center for Senior Life

406 Rigsbee Avenue | Durham, North Carolina 27701

Participant Name:_______________________________________ Birth Date ______________________

TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

I request and authorize the above-named participant be administered these medications(s) and/or treatment(s) in accordance with the instructions provided until an order to discontinue is received.

NAME OF MEDICATION OR TREATMENT	DOSAGE	ROUTE /METHOD OF ADMINISTRATION	TIME(S) TO BE ADMINISTERED AT PROGRAM	ANY PARAMETERS OR SPECIAL INSTRUCTIONS

Please clearly print legible instructions. ***It is required that you specify the times be given/ done at the day program.***
Prescriptions written for participants for administration at program are also acceptable, if all requirement above are met.

ROUTINE STANDING ORDERS

I understand that these may be administered to the above-named participant at the DCSL Adult Day Health Center

YES OR NO	MYLANTA – 15 TO 30 CC; every 4 hours PRN indigestion
YES OR NO	TUMS – Chew 1 to 2 tablets; PRN gas or indigestion
YES OR NO	TYLENOL TABLET 325 MG. – 1 TO 2 tabs every 4 hours PRN pain
YES OR NO	TYLENOL TABLET 500 MG. – 1 to 2 tabs every 4 hours PRN pain
YES OR NO	ROBITUSSION – 1 to 2 teaspoons every 4 to 5 hours PRN cough
YES OR NO	ANTIBIOTIC OINTMENT – apply thin film to affected skin tear/abrasion PRN *(area may be first cleaned with peroxide, normal saline or betadine)*
YES OR NO	ACCUCHECK – blood sugar as directed by physician and or PRN for s/s of Hyperglycemia

Licensed Health Professional Signature:____ Date:___________________

Phone Number:________________________________ Fax #:______________________

____ _________________________

Caregiver / Responsible Party Signature Date

Note: Adult Day Health keeps Tylenol on hand. Please supply the other items that may be needed. All medications and over the counter medications must be in a pharmacy labeled bottle.