Evergreen
Adult Day Services

3434 Kildaire Farm Road, #129
Cary, NC 27518
(919) 238-4738
fax (844) 363-9442
www.EvergreenAdultDayServices.net

PHYSICIAN'S HEALTH ASSESSMENT / MEDICAL INFORMATION AND AUTHORIZATION FOR TREATMENT

Participant Name: _____ Date: _____

D.O.B.: _____ Age: _____ Sex: _____
Height: _____ Heart Rate: _____ Temperature: _____
Weight: _____ Blood Pressure: _____ Respirations: _____

Primary Diagnosis: _____ ICD-10: _____
Secondary Dx: _____ ICD-10: _____
Other Dx: _____
Prognosis: _____
Allergies: _____

Medications (dosage, frequency and indication):

Medication	Dosage	Frequency	Indication

☐ **TB skin test**	Date given:	Date read:
	Read by:	Reaction:
☐ **Chest x-ray:**	Date:	Results:

Cardiovascular:	Gastrointestinal:
Musculoskeletal:	Rectal:
Mouth/Throat:	Endocrine:
Respiratory:	Genitourinary:
Integumentary:	Eyes:
Nose/Ears:	Psychological:

ASSISTIVE EQUIPMENT USED:

☐ Walker ☐Quad Cane ☐ Single point cane ☐Wheel chair

☐ Glasses ☐ Hearing Aid ☐ Dentures ☐ Other: _____

Mental Health Status:

☐ Confusion	☐ Hallucinations	☐ Disorientation	☐ Insomnia
☐ Depression	☐ Anxiety	☐ Delusions	☐ Wandering
☐ Suspiciousness	☐ Memory Loss	☐ Loss of Interest	☐ Impaired Judgment
☐ Loss of Interest	☐ Loss of Appetite	☐ Alcoholism	☐ Drug Abuse

☐ Other: _____

Falls Risk: Is this person at increased risk for falls? _____

Other Pertinent Health History: _____

MAY WE HAVE STANDING ORDERS FOR: (Please Check off)

Tylenol 500 mg. 1 or 2 tabs po q 3-4 h PRN pain	☐Y	☐N
Mylanta 30 cc po q4h prn gastric discomfort	☐Y	☐N
Kaopectate 4-8 tabs po q4h PRN diarrhea	☐Y	☐N
Oxygen 3-4L/min. PRN dyspnea	☐Y	☐N
NTG 0.4mg SL PRN chest pain (1dose per 3 min x 3 doses, then 911 w/no relief)	☐Y	☐N

Additional Standing orders: _____

_____

_____

Diet: We provide a regular diet. Does your patient require a **special diet**?

☐ No ☐ Yes (Please specify): _____

Activity Order: Ad Lib / Light exercises in sitting position / Assisted transfers / other:_____

_____

Additional orders or comments: _____

_____

_____

_____

Physician Signature_____ Date: _____

Physician's full name_____ Phone: _____

Physician's Address: _____

ADDITIONAL MEDICATION LIST

Participant Name: _____ Date: _____

Allergies: _____

State regulations require that all medication to be administered within the Adult Dare Service program be in the original container from the doctor or pharmacy. The containers must be clearly marked with the participant's full name, name and strength of the medicine, the dosage, frequency and instructions for administration. Only medications that meet these requirements will be given. Most pharmacies will give two containers of medication of asked.

Medications (dosage, frequency and indication):

Medication	Dosage	Frequency	Indication

Applicant Signature_____ Date: _____

Responsible Party Signature_____ Date: _____