Evergreen
Adult Day Services

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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: _____

Constitutional:	Musculoskeletal:
Eyes:	Integumentary:
Ears / Nose / Mouth /Throat:	Neurological:
Cardiovascular:	Psychiatric:
Respiratory:	Endocrine:
Gastrointestinal:	Hematologic / Lymphatic:
Genitourinary:	Allergic/Immunologic:

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: _____

Diet: Does your patient require a **special diet**? ☐ No ☐ Yes (Please specify): _____

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

_____

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

Other Pertinent Health History: _____

TB test (Optional)	☐ **skin test**	☐ **chest x-ray:**
	Date given: Date read:	Date:
	Read by:	Results:

Vaccines (Optional)	☐ **flu vaccine**	☐ **pneumonia vaccine**
	Date:	Date:

OTC Medication STANDING ORDERS per package instructions: (Please check)

Tylenol 500 mg ☐Y ☐N	Tums ☐Y ☐N
Ibuprofen 200 mg ☐Y ☐N	Mylanta ☐Y ☐N
Aspirin 325 mg ☐Y ☐N	Simethicone ☐Y ☐N
Benadryl 25 mg ☐Y ☐N	Kaopectate ☐Y ☐N
Dextromethorphan ☐Y ☐N	Colace ☐Y ☐N
Guaifenesin ☐Y ☐N	Milk of Magnesia ☐Y ☐N

Additional orders or comments: _____

_____

_____

_____

_____

_____

Physician Signature_____ Date: _____

Physician's full name_____ Phone: _____

Physician's Address: _____

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: _____

Participant Name: _____