Evergreen
Adult Day Services

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

Participant Name: _____ Date of Birth: _____

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: |

**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: _____

(To be completed by a medical provider)

Participant Name: _____ Date of Birth: _____

**ASSISTIVE EQUIPMENT USED:**

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

☐ Glasses ☐ Hearing Aid ☐ Dentures ☐ 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: _____

# CURRENT MEDICATION LIST

Participant Name: _____ Date of Birth: _____

**Allergies:** _____

| Medication | Dosage | Frequency | Indication |
|---|---|---|---|
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Physician Signature_____ Date: _____

**Family/Caregiver:**

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.

Responsible Party Signature_____ Date: _____

(To be completed by a medical provider)