Active Life Adult Day Care
Adult Day Health Program
17 Darrin Road, Dracut, MA 01826
Phone – (978) 322-0092/ Fax: (978)-596-1481

Primary Care Physician's Documentation

Participant Name: _____ D.O.B.: _____
Address: _____
Phone #: _____ Gender: Male_____ Female_____

Authorization for Release of Medical Information

I hereby authorize my physician to release all applicable and relevant medical information to the Adult Day Health program for inclusion in the individual's records.

Signature of Participant: _____ Date: _____
Staff person: _____ Date: _____

Medical History

1- Communicable Disease: _____
2- PPD Placed on Date: _____ PPD Read on Date: _____
Result of TB:
Result of chest X-Ray _____
If there is no TB record authorize chest X-Ray: Yes _____ / No _____

3- Date of last physical examination: _____
4- Diagnosis: _____
_____
_____
5- Dates of hospitalizations & condition treated for, in past 2 years: _____
_____
_____
6. Functional Limitations: _____
7.Date of Last Vaccinations:
Influenza: _____ Pneumococcal: _____ Tetanus: _____

Current Medications

Medication	Dosage	Route	Frequency

Is this patient capable of self-administration of medications? ____Yes ___No
Is there any significant medical history and ***Allergies*** the ADHC needs to know?

Drug Allergies: No _____ Yes _____: if yes please list_____
Food Allergies: No _____ Yes_____: if yes please list _____

General Physical Condition: Good Fair Poor
Mental Status: Alert & Oriented Confused Lethargic
Memory Deficit: None Mild Moderate Severe
Specific Problem:
Speech: Normal Aphasic _____ **Incontinence – Bladder:** Yes, No **Bowel:** Yes No
Vision: Normal Eyeglasses Contacts **Circulatory:** Normal Edema
Hearing: Normal Hearing Aid **R L** **Respiratory:** Normal Dyspnea
Dentures: Lower Upper **Cardiac:** Normal Arrhythmia Pacemaker

Diet and Nutrition

(Our Regular Diet is a Low fat/cholesterol NAS, 2-4g max diet.)

_____Regular	_____Diabetic
_____No salt added (2500-4500 mg. NA)	_____Special considerations (chopped, ground, choking precautions etc.)
_____Liberal diabetic (diet dessert, no sugar added)	Other

Ambulation

Alone	Supervision	Assist	Cane
Walker	Wheelchair	Quad Cane	Paralysis

Vitals

Weight:	Heart rate: ®: (AP):
Height:	Blood Pressure:
Temperature:	History of Seizures: ___Yes ____No

Physical Findings:

Normal		Comments (if any)	Normal		Comments (if any)
	Head			Respiratory	
	Eyes			Abdomen	
	Ears			Cardiac	
	Nose			Vascular	
	Throat			Genito-Urinary (M)	
	Skin			Genito-Urinary (F)	
	Other			Neuro-Psychiatric	
Previous Injuries, Falls, Fractures: Yes No			Comments:		

Recommendations for therapy

PT
OT

Nursing Considerations

Blood pressure, pulse and weight will be measured at least monthly for all participants. **If your patient needs more frequent monitoring and/or needs specialized nursing care, please specify**:

_____

_____

Please indicate if RN needs to provide:
Finger stick: RBS/ PRN _____ Assess LE edema: Weekly/PRN _____
SO2: Bi-W/PRN _____ Other: _____

_____

Physician Authorization

I hereby give my consent for this individual to attend the Adult Day Health Center.

Physician's signature:	Address:
Printed name:	Phone:
Date:	Fax:

PatientName_____ **DOB**_____

New Diagnosis: - _____ **ICD 10 Codes: -**_____

SKILLED NURSING SERVICES PROVIDED AT ACTIVELIFE ADULT DAY CARE (Check all apply)

□ Skilled Observation □ Cardiopulmonary Status □ Cognitive/Mental Status □ Neurological Status □ Diabetes _____

□ Oxygen Saturation prn SOB □ Blood Sugar Testing & Call Physician if BS < 60 or > 350

□ Assess and Monitor (Specify) _____ □ Administer enteral feeds. _____

□ Monitor Vital Signs ___ Monthly or Other Frequency _____; Notify Physician if Specify Parameters _____

□ Monitor Weight _____ Monthly or Other Frequency_____ □ Assess and Monitor Nutritional Status

□ May administer medications at the ALADC □ Monitor medications response, effectiveness, and side effects.

□ Behavioral Management _____ □ Therapeutic Activities

□ Additional Orders _____

ADL RECOMMENDATION TO ACTIVELIFE ADULT DAY CARE

Ambulation: -□ Independent □ Cane □ Walker □ Wheelchair □ Assist

Transfer: -□ Independent □ Supervision / Cueing □ Assist

Dressing: □ Independent □ Supervision / Cueing □ Assist

Toileting: -□ Independent □ Supervision / Cueing □ Assist / **Bathing: -** □ Occasionally □ Regularly

Eating: - □ Supervision / Cueing □ Assist / **Diet Consistency: -** □ Regular □ Mechanical Soft □ Puree

ROUTINE MEDICATIONS ORDERS

□ Tylenol 325mg, 1-2 tablets po q4-6 prn pain _____ □ Ibuprofen 200mg po q4-6 prn pain _____

□ Maalox (x-strength) 10cc po q4hrs PRN GI distress _____ □ TUMS (750mg) 1-2tabs q6hrs prn heartburn_____

□ MOM 30cc po q12hrs PRN constipation _____ □ Kaopectate 30cc po q6hr PRN for diarrhea _____

□ Robitussin/diabetic tussin (if applies) 10ml q4hrs prn cough _____

□ Benadryl 25mg 1-2 tabs q4-6hrs prn hay fever, allergies _____

□ Epipen (1:1000 0.3ml) – SC for sings and symptoms (dyspnea, cyanosis, hypotension) of suspected anaphylaxic reaction.___

Permitted to go to Field Trip □ YES □ NO

Flu Vaccine: 0.5 cc IM, if requested (October to February, yearly).

Cut/Abrasions: Wash with normal saline solution. Apply antibiotic ointment. Cover with dressings if necessary.

DO YOU AGREE WITH THE ABOVE STANDING ORDERS? ☐ **YES** ☐ **NO**

***Please Attach a recent PHYSICAL EXAM, OFFICE VISIT NOTES & CURRENT MEDICATION LIST**

Comment/OtherOrders: _____

I hereby certify that this patient is appropriate for adult day health services.

_____ _____

Physician's Signature **Date**

Physician's Name (typed or printed)

Physician's Address