Enhancing Life Adult Day Center
10721 Tidewater Trail
Fredericksburg, VA 22408
(540)693-1331 (fax) (540)479-2412

I hereby authorize _____ MD, to release any information in my medical records, deemed necessary for my care, to Enhancing Life Adult Day Center.

Name of patient: _____ Signature_____

Address: _____ Date of Birth:_____

City, State, ZIP: _____ Phone: _____

MEDICAL STATEMENT

Date of most recent examination (within 30 days of acceptance for admission): _____
If this is a pre-admission physical exam, please attach **TB screening form with this Medical Statement

Primary diagnoses/significant medical problems:_____

_____

_____

Significant medical history:_____

_____

_____

General physical condition, including a systems review as is medically indicated:_____

_____

_____

_____

Restrictions, precautions or limitations on physical activities or program participation:_____

_____

_____

Recommendations for care:_____

_____

_____

Therapy, treatments, or procedures participant is undergoing, or should receive, and by whom:

_____

_____

_____

Known allergies (food, medicine, other) and description of reaction to allergen:_____

_____

_____

Height: _____ Weight: _____ Blood pressure: _____

Is this person capable of administering their own medications without assistance? **YES** or **NO**

Is this person capable of making decision to be transported to hospital in an emergency? **YES** or **NO**

Does the patient have a Durable Do Not Resuscitate order? (please provide copy) **YES** or **NO**

Is this person Ambulatory? * **YES** or **NO**

* Ambulatory means that participant is physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area without the assistance of another person, or from the structure itself without the assistance of another person even if the participant may require the assistance of a wheelchair, walker, cane, prosthetic device or a single verbal command to evacuate.

STANDING ORDERS

Please select all that apply:

Diet: Regular Diabetic

Consistency: Regular Chopped Pureed

Please list any foods/liquids patient should not have:_____

Please list any other dietary restrictions or limitations:_____

- ❑ Tylenol 500mg tablet, 2 tablets PO every 4 hours PRN for Musculoskeletal pain, headache and/or fever
- ❑ Ibuprofen 200mg tablet, 2 tablets PO every 6 hours PRN for Musculoskeletal pain, headache and/or fever

All above PRNs may be repeated x1 dose per day if needed unless otherwise noted.

- ❑ Triple antibiotic ointment topically and bandage, 1 application daily PRN for minor abrasions
- ❑ Other:_____

Diabetics only:

- ❑ Check blood sugar (give frequency):_____
- ❑ Check blood sugar PRN for signs and symptoms of hypo/hyperglycemia

  Call MD if blood sugar is less than _____ or greater than _____

  *********Family must provide a glucometer for use while at the center*************

Other instructions (please be specific):_____

_____

_____

CURRENT MEDICATION ORDERS

Please review the medication list with the patient's family during the office visit for Enhancing Life to have the most comprehensive medications list on file.

***if providing an additional medication list, please sign and date it, and write “see attached” below or MD sign and date medication list provided

Medications (Rx and OTC)	Strength	Dosage	Route	Frequency of administration

Physician Signature: _____ Date:_____

Physician Printed Name: _____

Address: _____

Phone: _____ FAX: _____

ENHANCING Life
ADULT DAY CENTER

REPORT OF TUBERCULOSIS SCREENING

Date: _____

Name: _____ Date of Birth: _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility/practice)

- ❑ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.
- ❑ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.
- ❑ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.
- ❑ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)

Print Name/Title: _____ Phone: _____

Address: _____

_____

_____

ENHANCING Life
ADULT DAY CENTER

REPORT OF TUBERCULOSIS SCREENING

Name: _____ Date of Birth: _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by **_____.**
(Name of health dept/facility/practice)

Chest X-ray Report – No active disease Date of Chest X-ray: _____

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)

Print Name/Title: _____ Phone: _____

Address: _____

Chest X-ray Report – Abnormal Report Date of Chest X-ray: _____

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)

Print Name/Title: _____ Phone: _____

Address: _____

Tuberculin Skin Test (PPD) Date given: _____ Date read: _____

Results: _____ mm _____ Negative _____ Positive

Based on the above information the above named individual can be considered free of tuberculosis in communicable form.

Signature/Title _____ Date _____
(MD/designee or Health Department Official)

Print Name/Title: _____ Phone: _____

Address _____