SarahCare® of Coral Springs **Adult Day Care** Center

Date of Request		Physician	
Phone #		Fax #	
Participant's Name		Participant's DOB	

Medical Questionnaire and Standing Orders Form

Please complete the below information and
ATTACH the most recent **History, Physical** & **MEDICATION LIST**.

Do you recommend this individual for an **Adult Day Care** program? ☐ Yes ☐ No

Is this individual able to **self-administer medications**? ☐ Yes ☐ No

Does individual have a **communicable disease**? ☐ Yes ☐ No If Yes, please explain: _____

Allergies (☐ list provided) _____

TB: Test date: _____ Result: ☐ Negative ☐ Positive

Chest X-ray date: _____ Result: ☐ Negative result for TB ☐ Positive result for TB

Dietary Needs: ☐Regular ☐No added table salt ☐Low fat ☐Diabetic ☐No added sugar

☐No raw fruits/vegetables ☐Other: _____

Dysphagia: ☐Yes ☐No Requires food ☐Chopped: _____ ☐ Pureed: _____

Thickened Liquids: ☐Yes ☐No ☐Nectar consistency ☐Honey consistency ☐Pudding consistency

Primary Diagnosis: _____ , _____ , _____,

_____ , _____ , _____,

_____ , _____, _____

Is SarahCare Nurse able to administer (OTC) Over-The-Counter products. Please Check YES or NO	**Yes**	**No**
Tylenol 325 mg. 1 or 2 tablets every 4 hours as needed for pain or fever		
Ibuprofen 200 mg. 1 or 2 tablets every 4 hours as needed for pain or fever		
Maalox 30cc every 4 hours as needed for stomach upset		
Imodium 2mg once daily as needed for sudden diarrhea		
OTC **Cough Drop** every 2 hours as needed for cough		
OTC **Cough Suppressant Liquid** every 4 hours as needed for cough		
Tums 1 or 2 tablets every 4 hours as needed for indigestion/heartburn		
May check **blood sugar** with finger stick testing unit as needed for s/s of hyper/hypoglycemia		
Minor wound care as needed; cleanse w/ normal saline; apply triple antibiotic & dressing		
Preliminary **urine dipstick test** for RBCs, WBCs, and Nitrates for s/s of UTI		
(MOM) Milk of Magnesia for constipation		

Physician's signature: _____

Physician's Printed Name: _____ Date: _____

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