Medical Questionnaire:

SarahCare®

Coral Springs Adult Day Care Center

Physician:	
Address:	
Phone:	
Fax:	
Date:	

Name: _____ **DOB:** _____ Most recent date seen by doctor: _____

BP: _____ T: _____ P: _____ R: _____ Wt: _____ Usual BP range: _____

TB

TB test results: Date: _____ ☐ Negative ☐ Positive (Or)Chest x-ray Date: _____

Chest x-ray results: ☐ Negative for TB ☐ Positive Treatment:

Allergies: (☐ List Provided) _____

Please check diagnosed conditions:

Alzheimer's Disease:	☐ Yes ☐ No	Dementia:	☐ Yes ☐ No	Hypothyroidism:	☐ Yes ☐ No
Anemia:	☐ Yes ☐ No	Depression:	☐ Yes ☐ No	Parkinson's dementia:	☐ Yes ☐ No
Anxiety:	☐ Yes ☐ No	Gastro/Intestinal:	☐ Yes ☐ No	Parkinson's Disease:	☐ Yes ☐ No
Arthritis:	☐ Yes ☐ No	Glandular Disorders:	☐ Yes ☐ No	PVD:	☐ Yes ☑ No
Balance Problems:	☐ Yes ☐ No	Glaucoma:	☐ Yes ☐ No	Stomach ulcers:	☐ Yes ☐ No
CAD:	☐ Yes ☐ No	H/O MI:	☐ Yes ☐ No	**Other:**	
Cataracts:	☐ Yes ☐ No	H/O UTI's	☐ Yes ☐ No		
CHF:	☐ Yes ☐ No	Hemorrhoids:	☐ Yes ☐ No		
Chronic Sinusitis:	☐ Yes ☐ No	Hepatitis:	☐ A ☐ B ☐ C		
Circulatory Problems:	☐ Yes ☐ No	Hernia:	☐ Yes ☐ No		
COPD:	☐ Yes ☐ No	HIV:	☐ Yes ☐ No		
CVA:	☐ Yes ☐ No	Hypertension:	☐ Yes ☐ No		

Diabetes: ☐ Yes ☐ No Type 1: ____ Type 2: ____ Brittle: ☐ Yes ☐ No Diabetic Neuropathy: ☐ Yes ☐ No

Hearing Impairment: ☐ Mild ☐ Moderate ☐ Severe ☐ Deaf ☐ Both Ears ☐ Left Ear ☐ Right Ear

Other urinary dysfunction (include type) _____

Hospitalizations in last year: ☐ Yes ☐ No Dates of Admission: _____

Reasons for hospitalization: _____

Please list any special precautions, functional limitations or conditions which with which we should be familiar:

_____

_____

Needs Oxygen: ☐ Yes ☐ No ☐ PRN ☐ Continuous ☐ Liter Flow ☐ Nasal cannula Other: _____

Dietary Needs: ☐ Regular ☐ No added table salt ☐ Low fat ☐ Diabetic ☐ No added sugar ☐ No raw fruits/vegetables

Texture Changes: ☐ Chopped Meat ☐ Pureed Meat ☐ Pureed Diet

Thicken Liquids: ☐ Nectar consistency ☐ Honey consistency Participant needs feeding assistance: ☐ Yes ☐ No

Participant will need feeding assistance: ☐ Yes ☐ No

MANDATORY

Medications (Dose, Route, Frequency) - May fill in or include computerized copy

_____ _____

_____ _____

_____ _____

_____ _____

Physician's Signature: _____ **Date:** _____

Printed Physician's Name _____

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SarahCare®

Coral Springs Adult Day Care Center

ANNUAL STANDING ORDERS

We are faxing you our Annual Mandatory Standing Order Form which needs be signed and faxed back to us as soon as possible. Please review the standing orders and mark YES or NO if the Patient is able to take the listed **Non Prescription Medications** while at our Adult Day Care Center. Thank you in advance.

Patient Name:_____ **DOB:**_____

Physician:_____ **Physician Fax#:**_____

The following orders, once signed by the physician, are effective for 1 year and must be updated yearly.

	(Please mark YES or NO)	**YES**	**NO**
1.	**Tylenol** 325 mg. 1 or 2 tablets every 4 hours as needed for pain or fever	☐	☐
2.	**Maalox** 30cc every 4 hours as needed for stomach upset	☐	☐
3.	Over the counter **cough drop** every 2 hours as needed for cough	☐	☐
4.	**Tums** 1 or 2 tablets every 4 hours as needed for indigestion/heartburn	☐	☐
5.	May check **blood sugar with finger stick testing unit** as needed for signs/symptoms of hyper/hypoglycemia	☐	☐
6.	**Minor wound care** as needed-cleanse with warm water and soap, apply triple antibiotic and dressing	☐	☐
7.	**Imodium** (Loperamide HCL) Anti-Diarrhea 30cc PRN	☐	☐
8.	May check **urine dipstick** as needed for signs and symptoms of urinary tract infection	☐	☐
9.	**Milk Of Magnesia** for constipation 30cc PRN	☐	☐

_____ _____

Physician Signature **Date**

Comments: _____

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