

# SarahCare<sup>®</sup> 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

If No, please explain: \_\_\_\_\_

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:** \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ ,

\_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

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

Please check either Yes or No for each item below (Allowable OTC)	Yes	No
<b>Tylenol</b> 325 mg. 1 or 2 tablets every 4 hours as needed for pain or fever		
<b>Ibuprofen</b> 200 mg. 1 or 2 tablets every 4 hours as needed for pain or fever		
<b>Maalox</b> 30cc every 4 hours as needed for stomach upset		
<b>Imodium</b> 2mg once daily as needed for sudden diarrhea		
Over the counter <b>cough drop</b> every 2 hours as needed for cough		
<b>Tums</b> 1 or 2 tablets every 4 hours as needed for indigestion/heartburn		
May check <b>blood sugar</b> with finger stick testing unit as needed for s/s of hyper/hypoglycemia		
<b>Minor wound care</b> as needed; cleanse w/ normal saline; apply triple antibiotic & dressing		
Preliminary <b>urine dipstick test</b> for RBCs, WBCs, and Nitrates for s/s of UTI		

Physician's signature: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_