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

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

Annual 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) _____

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
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		

Physician's signature:_____

Physician's Printed Name:_____ Date: _____

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SarahCare®

Coral Springs Adult Day Care Center

State regulations require each member to get an annual

TB TEST (or) **CHEST X-RAY**

Chest X-Ray cannot be more than 45 days old.

TURERCULIN SKIN TEST

Patient Name:_____ DOB: _____

Date Administered: _____ Administered by: _____

Area: _____

Date Read: _____ Read by: _____

Size: _____mm

Result: Negative: _____ Positive: _____

If positive, please attach x-ray

results. Comments:

_____

_____

CHEST X-RAY

Patient Name: _____ DOB: _____

Date of X-Ray:_____

Result:_____

Medical Facility Signature:_____

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