AMONG FRIENDS
Adult Day Health Care Center

851 S. A Street
Oxnard, CA 93030
Tel. 805.385.7244
Fax 805.385.7246
Email: info@amongfriends.org

PHYSICIAN AUTHORIZATION

Name:		Telephone:	
Address:		Gender: ❑ Male ❑ Female	
City:	Zip:	DOB:	SSN:

Current Medical Exam

Diagnosis	ICD Code	Normal	Normal
		General	Lungs
		H.E.E.N.T.	Heart
		Mouth	Abdomen
		Thorax	Genitourinary
		Breast	Musco-skeletal
		Lymphatic	Rectal
		Special Instructions:	

Diet and Nutrition

❑ Regular ❑ Low NA ❑ Low Cholesterol
❑ Diabetic ❑ Puree ❑ Renal ❑ Other_____

Allergies

Does patient have any known allergies? ❑ No ❑ Yes _____

Okay for PRN use while at center

Pain - okay to substitute generic
❑ Aspirin (5g), 2 tablets, q 4 hours with food ❑ Advil (200mg), 1 tablet, q 4 hours with food
❑ Tylenol (325mg), 2 tablets, q 4 hours ❑ Other: _____

Stomach Upset/ Intestinal Distress -okay to substitute generic
❑ Antacid (Maalox), 30cc, q 4 hours ❑ Laxative (M.O.M.), 30cc, prn QD constipation
❑ Kaopectate, 2 tbs up to 3x/day prn diarrhea ❑ Pepto Bismol, 30ml, q 30-60 minutes, prn diarrhea

TB clearance (within the last 12 months) – Required prior to admission into the program

Date / Result of TB Test: ❑ Negative ❑ Positive **Method:** ❑ PPD Test ❑ Chest XRAY

Do you authorize licensed nursing staff to administer a PPD skin test at the center? ❑ No ❑ Yes
Any indication of a communicable disease? ❑ No ❑ Yes (If yes, please explain)_____

Special Orders

All participants attending the center are monitored by an RN, who will notify you of any significant problems.
Blood glucose testing order? ❑ Yes ❑ No Frequency: ❑ Daily ❑ Weekly ❑ Other: _____

Do you wish to be notified if:

Blood Sugar: 2 HRS. AC breakfast <70mg/dl >140mg/dl ❑ Yes ❑ No
If BS <70 mg/dl offer 120cc. juice/milk ❑ Yes
Other Parameters:_____

Blood Pressure: <90/60- >160/90 ❑ Yes ❑ No
❑ Other Parameters: _____

Pulse: <60>110 ❑ Yes ❑ No
❑ Other Parameters_____

Does patient have any medical contraindications for transportation time in excess of 60 minutes?
❑ No ❑ Yes (If yes, please explain) _____

I AUTHORIZE PARTICIPATION AT AMONG FRIENDS ADHC

Physician Authorization

Physician Printed name:	Date:
Physician's Signature	Telephone:

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Name:		Telephone:
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Medications

Medication Name	Dosage	Directions	Prescribing MD	Diagnosis
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Is this patient capable of self-administration of medications while at the center?	❑ **Yes**	❑ **No**

Physician Recommendations

Physician Authorization

Printed name:	Date:
Physician's signature:	Telephone: