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:	DOB:	Gender: ☐ Male ☐ Female
Address:	City:	Zip:

* If EHR is attached, you may skip Sxn I

I. Diagnosis and Current Medical Exam

Diagnosis	ICD Code	Current Medical Exam	
		Normal	Normal
		General	Lungs
		H.E.E.N.T.	Heart
		Mouth	Abdomen
		Thorax	Genitourinary
		Chest	Musculoskeletal
		Lymphatic	Rectal

Please Complete All of Sxns II – VII

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

PPD Test	QuantiFERON Test	Chest X-Ray
Date Read:_____	Date: _____	Date: _____
Result: ☐ Negative ☐ Positive	Result: ☐ Negative ☐ Positive	Result: ☐ Negative ☐ Positive

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

III. Diet and Nutrition

☐ Regular ☐ Low NA ☐ Low Cholesterol ☐ Diabetic ☐ Renal ☐ Other_____
☐ Puree ☐ Chopped ☐ Mechanical Soft ☐ Fluid Restriction_____ ☐ Other_____

IV. Allergies

Does patient have any known allergies (food / medication / etc)? ☐ No ☐ Yes _____

V. Okay for PRN use while at center (Standing Orders)

Pain - Okay to substitute generic	Stomach Upset / Intestinal Distress - Okay to substitute generic
☐ Advil (200mg), 1 tablet, q4 hours with food OR ☐ Tylenol (325mg), 2 tablets, q6 hours	☐ Antacid (Maalox), 30cc, q4 hours, prn indigestion ☐ Kaopectate, 2 tbs up to 3x/day prn diarrhea ☐ Laxative (M.O.M.), 30cc, prn QDaily constipation

VI. 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 ☐ Other: _____

MD will be notified of findings outside of stated parameter range. MD may adjust by entering alternative range

Blood Sugar: 2 HRS. AC breakfast <70mg/dl >140mg/dl	Blood Pressure: < 90/60 > 160/90	Pulse: <60>110bpm
Alternative Range: _____	Alternative Range: _____	Alt Range: _____

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

VII. Physician Authorization

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

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VIII. Medications

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

Pls Complete All of Sxns IX –XI

IX. Medication Self Administration

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

X. Risk Factors

Hx of Falls? ☐ No ☐ Yes If Yes, Explain:	Recent ER / Hospitalization (w/in 6 mos)? ☐ No ☐ Yes If Yes, Explain:

XI. Physician Authorization

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