

PHYSICIAN AUTHORIZATION

Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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

II. TB clearance (within the last 12 months) – Required prior to admission into the program		
<u>PPD Test</u>	<u>QuantiFERON Test</u>	<u>Chest X-Ray</u>
Date Read: _____	Date: _____	Date: _____
Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Do you authorize licensed nursing staff to administer a PPD skin test at the center? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any indication of a communicable disease? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please explain) _____		

III. Diet and Nutrition	
<input type="checkbox"/> Regular Diet <input type="checkbox"/> Low NA <input type="checkbox"/> Low Cholesterol <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal <input type="checkbox"/> Fluid Restriction _____ <input type="checkbox"/> Other _____	
<input type="checkbox"/> Regular Consistency Solids & Liquids <input type="checkbox"/> Thickened Liquids <input type="checkbox"/> Puree Solids & Soup <input type="checkbox"/> Chopped Solids & Blended Soup	

IV. Allergies	
Does patient have any known allergies (food / medication / etc.)? <input type="checkbox"/> NKA <input type="checkbox"/> Yes _____	

V. Okay for PRN use while at center (Standing Orders)	
Pain - Okay to substitute generic	Stomach Upset / Intestinal Distress - Okay to substitute generic
<input type="checkbox"/> Advil (200mg), 1 tablet, q4 hours with food OR <input type="checkbox"/> Tylenol (325mg), 2 tablets, q6 hours	<input type="checkbox"/> Antacid (Maalox), 30cc, q4 hours, prn indigestion <input type="checkbox"/> Kaopectate, 2 tbs up to 3x/day prn diarrhea <input type="checkbox"/> 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 at center? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please explain) _____		

I AUTHORIZE PARTICIPATION AT AMONG FRIENDS ADHC	
VII. Physician Authorization	
Physician Printed name:	Date:
Physician's Signature	Telephone:

Please Complete All of Sxns II – VII

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Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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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.					

* If EHR is attached, you may skip Sxn VIII

Pls Complete All of Sxns IX -XI	IX. Medication Self Administration		
	Is this patient capable of self-administration of medications while at the center?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	X. Risk Factors		
	Hx of Falls? <input type="checkbox"/> No <input type="checkbox"/> Yes	Recent ER / Hospitalization (w/in 6 mos)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	If Yes, Explain:	If Yes, Explain:	
XI. Physician Authorization			
Printed name:		Date:	
Physician's signature:		Telephone:	