Annual Updated Form due by: _______________

MEDICAL FORM

Please Print
(Family –please fill out information only to the bolded line)

Patient (Participant) Information

Patient's (Participant's) Name: ____

Address: ____

Phone Number: ______________________ ***DOB:*** ______________________

Patient's (Participant's) POA/Responsible Party: ____________________________________

Relationship:______________________ Phone Number:________________________

I hereby authorize the release of any medical information by the physician to DayBreak at Garden Spot Village. I am also aware the medical evaluation needs to be completed by the physician ***within 90 days of enrollment and annually thereafter.***

Patient or POA's Signature: ______________________________ Date____________________

Please Print

(Form may be completed by a licensed physician, CRNP or licensed physician's assistant)

Medical & Cognitive Information

Diagnoses:

Primary: ____

Secondary: ____

Tertiary: ____

Physical Disabilities/Limitations: ____

Cognitive Status: ____

Medical History (Recent hospitalizations, surgeries, etc.)___________________________

____

____

Height: ___________ Weight: ___________ TPR: ______________ BP:___________

Check with an ***X*** *if abnormal*:

☐ Eyes ☐ Ears ☐ Nose ☐ Throat ☐ Mouth ☐ Breasts ☐ Lungs ☐ Heart

☐ Heart ☐ Arteries ☐ Abdomen ☐ Hernia ☐ Skin ☐ Neck ☐ Veins ☐ Anorectal

☐ Gynecological ☐ Lymph System ☐ Nervous system ☐ Extremities ☐ Musculoskeletal

Describe any abnormalities: ____

____

Sensory Impairments and Aids

Vision: ___________ Hearing: ___________ Walker: ☐ Cane: ☐ Wheelchair: ☐

☐Other__________________

Other Medical / Misc. Information

Ability to participate in senior exercise program: ____

Ability to participate in a supervised senior swimming/water exercise program: ☐ Yes ☐ No

Allergies: ____

Diet: ____

Restrictions: ____

____

Other orders or instructions, including medical emergency instructions: ____________________________

____

Mental Functioning:

Mental capacity/ orientation: ____

____

Ability to follow instructions: ____

Capable of understanding client rights/plan of care? ☐ Yes ☐ No

Capable of self-administration of medications*? ☐ Yes ☐ No

* Per PA Code Title 6: Aging Chapter 11. Older Adult Daily Living Centers: *§11.147 Self-Administration of Medications:* (1) identify the medication (2) acknowledge the amount of, and schedule for, medication (3) remember to take the medication on schedule with infrequent reminders from staff persons and (4) obtain medication from its container without assistance or with minimal assistance.

Behaviors

Current Mental Health Treatment: ____

Current Emotional Challenges: ____

History of Mood/Behavior Challenges: ____

Verbal/Physical aggression: ____

Wandering/Roaming: ____

Sexual Behaviors:____

Repetitive Behaviors (physical or verbal): ____

Other Behaviors: ____

Tuberculin Skin Test (within 2 years)

(Acceptable tuberculin skin tests: one step Mantoux (TST), two step Mantoux (TST), Quantiferon Gold and T-Spot blood test)

Date Given: ________________

Date Read: _________________

PPD Test Results: ___________

Signature & Title of Person Reading test results: ____

If TB skin test is positive, a chest X-ray is required. Please provide *date* and *result* of chest X-Ray:

Date: ____________ Result_________________________

Free of Communicable Disease Statement

"To the extent that confidentiality laws permit, please indicate that this patient (participant) is free of communicable disease or is able to be in the center if specific precautions are taken which will prevent the spread of the disease to other individuals" *(P*er PA Code Title 6. Aging Chapter 11. Older Adult Daily Living Centers: §*11.133 Communicable Disease).*

Is Patient/Participant Free of Communicable Disease? Yes __________ No* __________

*If checked no, please outline the specific instructions and precautions to be followed to ensure protection of other persons at the center (as per state regulations cited above):

____

____

____

Medications

Drug	Dosage	Frequency/Route	Indication for Use

____

____

I authorize the administration of the following OTC medications according to the manufacturer's directions or the physician's instructions listed below. Check those that apply with an X.

___TYLENOL 325 mg. 2 tablets q 4-6 hour for pain or fever
___ TYLENOL 500 mg. 2 caplets q 4-6 hours for pain or fever
___ TUMS 2-4 tabs PRN
___ Normal Saline Cleanse and Triple Antibiotic Ointment for first aid measures – daily/PRN

Medication Instructions: ____

I have thoroughly examined ____ on _____________ and find that:

- *he/she is **not** in need of hospital care*
- *does **not** require bed rest during the day*
- *is **not** addicted to drugs and/or alcohol*
- *is **not** appropriate for skilled nursing services*

He/she is able to participate in the programming at DayBreak at Garden Spot Village.

Physician's Signature: ____ Date: _____________

Physician's License Number: ____

Physician's Name (print): ____

Physician's Address: ____

Physician's Phone #: ______________________________ Fax #: _______________________________

Please make sure form is filled out in its entirety

Return completed Medical Form to:

DayBreak at Garden Spot Village
433 S. Kinzer Avenue, New Holland, PA 17557
Office: (717) 355-6226
Fax: (717) 355-6222