

PHYSICIAN AUTHORIZATION

Participant Name:		Telephone:	
Address:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City:	Zip:	DOB:	SSN:

Current Medical Exam

Diagnosis	ICD-9 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

<input type="checkbox"/> Regular	<input type="checkbox"/> Low NA	<input type="checkbox"/> Low Cholesterol	
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Puree	<input type="checkbox"/> Renal	<input type="checkbox"/> Other: _____

Allergies

Does patient have any known allergies? No Yes _____

Okay for PRN use while at the center

Pain	
<input type="checkbox"/> Aspirin (5g), 2 tablets, q 4 hours with food	<input type="checkbox"/> Advil (200mg), 1 tablet, q 4 hours with food
<input type="checkbox"/> Tylenol (325mg), 2 tablets, q 4 hours	<input type="checkbox"/> Other: _____
Stomach Upset/ Intestinal Distress	
<input type="checkbox"/> Antacid, 30cc, q 4 hours	<input type="checkbox"/> Laxative (M.O.M.), 30cc, prn QD constipation
<input type="checkbox"/> Kaopectate, 2 tbs, prn diarrhea	<input type="checkbox"/> Pepto Bismol, 30ml, q 30-60 minutes, prn diarrhea

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

Date of test:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	Method:	<input type="checkbox"/> PPD Test <input type="checkbox"/> Chest XRAY
Do you authorize licensed nursing staff to administer a PPD skin test at the center?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Any indication of a communicable disease? <input type="checkbox"/> No <input type="checkbox"/> 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: 70 >250 mg/dl AC lunch <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood pressure: <90/60- >160/90 <input type="checkbox"/> Yes <input type="checkbox"/> No
2 HRS. PC breakfast <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other Parameters: _____
If BS <70 mg/dl offer 120cc. juice/milk <input type="checkbox"/> Yes	
Other: _____	

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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MEDICATIONS

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

Is this patient capable of self-administration of medications? Yes No (reason): ↑
 Does patient require meds to be administered to them at center? No Yes: (If yes, check box above to indicate meds)

PHYSICIAN RECOMMENDATIONS

PHYSICIAN AUTHORIZATION

Printed name:	Date:
Physician's signature	Telephone: