CIRCLE CENTER ADULT DAY SERVICES
4900 West Marshall Street
Richmond, Virginia 23230
(804) 355-5717 (Fax) (804) 358-3866

I HEREBY AUTHORIZE _____ MD, TO RELEASE ANY INFORMATION IN MY MEDICAL RECORDS TO CIRCLE CENTER ADULT DAY SERVICES.

Name of Patient: _____ Signature: _____

Address: _____

_____

_____

ADMISSION MEDICAL STATEMENT

HEALTH DATA: Date of most recent examination (within 30 days of admission) _____

The attached report concerning TB screening must be completed and returned with this Medical Statement.

Primary Diagnoses: _____

Secondary Diagnoses: _____

Limitations/Precautions: _____

Allergies: _____

Most Recent Vital Signs _____ Most Recent Weight: _____

Capable of administering own medication? ☐ Yes ☐ Supervised ☐ No

Capable of making decision to be transported to hospital in an emergency? ☐ Yes ☐ No

Capable of exiting a building in an emergency without assistance? ☐ Yes ☐ No

Does patient have a Do Not Resuscitate (DNR) order in your office? ☐ Yes ☐ No

If yes, we ask that you send a copy with this medical statement

STANDING ORDERS

Please choose all appropriate options

Diet: ☐ **Regular** ☐ **Diabetic**

Consistency: ☐ **Regular** ☐ **Chopped** ☐ **Pureed**

Please list any foods/liquids patient should not have:

☐ **Dairy (CCADS will offer a substitute i.e. soy or almond milk)**

Other: _____

PRNs:

☐ **Tylenol 500mg tablet, 2 tablets PO every 4 hours PRN for Musculoskeletal pain, Headache, and/or Fever.**

☐ **Ibuprofen 200mg tablet, 2 tablets PO every 6 hours PRN for Musculoskeletal pain, Headache, and/or Fever.**

All above PRNs may be repeated x1 dose per day if needed unless otherwise specified.

☐ **Triple Antibiotic ointment topically and bandage, 1 application daily PRN for Minor Abrasions.**

☐ **Benadryl 25mg tablet, one tablet PO x1 dose PRN for allergic reaction i.e. itching, rash, and/or hives. MD will be called if ineffective.**

DIABETICS ONLY:

Check blood sugar (give frequency) _____.

☐ **Check blood sugar PRN for signs and symptoms of Hypo/Hyperglycemia.**

Call MD if blood sugar is <_____ or >_____

******** FAMILY MUST PROVIDE A GLUCOMETER WHICH IS KEPT AT CENTER********

Other, Please be specific with instructions:

_____

_____

ACTIVE MEDICATION ORDERS – Please review medication list with participant's family during office visit for CCADS to have most updated medication list on file.

***** If providing a medication list, please state "See Attached" or MD sign and date medication list provided.**

Date Rx	Medication	Strength	Dosage	Frequency	Route	Prescribing MD

***** May administer medications per family/participant's time scheduled at CCADS ☐ YES ☐ NO**

_____ _____

Date **Signature of Physician**

Name of Physician: _____

Address: _____

Phone# _____ **and Fax#** _____

REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ Date of Birth _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

☐ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

☐ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

☐ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

☐ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____
_____
_____

REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____Date of Birth _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

Tuberculin Skin Test (PPD)
Date given _____ Date read _____

Results : _____ mm _____ Negative _____ Positive

Signature _____ Date _____

(MD or Health Department Official)
Address _____ Phone _____

Chest X-ray Report – No active disease

Date of Chest x-ray _____

_____ No evidence of active tuberculosis

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____

(MD or Health Department Official)
Address _____ Phone _____

Chest X-ray Report – Abnormal Report

Date of Chest x-ray _____

_____ Chest x-ray abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature _____ Date _____

(MD or Health Department Official)

Address _____ Phone _____