



CIRCLE CENTER ADULT DAY SERVICES
4900 West Marshall Street
Richmond, Virginia 23230
(804) 355-5717 Fax: (844)466-2538

I hereby authorize _____ MD, to release any information in my medical records to Circle Center Adult Day Services.

Name of Patient: _____ Signature: _____

Address: _____

Phone: _____ DOB: _____

MEDICAL STATEMENT

Date of most recent examination (must be within 30 days of admission): _____

Attached TB screening must be completed and returned with this Medical Statement.

Primary Diagnoses/ Significant health problems: _____

Significant Medical History: _____

General Physical Condition/Systems Review (Attach H&P): _____

Limitations/Precautions: _____

Recommendations for Care: _____

Allergies: _____

Current Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____

Is this patient ambulatory? Yes No

Capable of administering own medication? Yes 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 Durable Do Not Resuscitate order? (Please provide copy) Yes No

STANDING ORDERS

Please choose all appropriate options

Diet: Regular Diabetic

Consistency: Regular Chopped Pureed

Please list any foods/liquids patient should not have: _____

No Dairy (CCADS will offer a substitute i.e. soy or almond milk)

Other: _____

Acetaminophen 500mg tablet, 2 tablets PO every 4 hours PRN musculoskeletal pain, headache, and/or fever. May be repeated x 1 dose per day if needed unless otherwise specified.

Ibuprofen 200mg tablet, 2 tablets PO every 6 hours PRN musculoskeletal pain, headache, and/or fever. May be repeated x 1 dose per day if needed unless otherwise specified.

Triple Antibiotic Ointment, 1 application topically to affected area daily PRN minor abrasions.

Benadryl 25mg tablet, 1 tablet PO x1 dose PRN allergic reaction (itching, rash, and/or Hives). Call MD 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 less than _____ or greater than _____

******* FAMILY MUST PROVIDE A GLUCOMETER TO BE KEPT AT CENTER *******

Other, please be specific with instructions:

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 _____