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

Patient's name: ___________________________ DOB: ___________________________

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:

____

Patient's name: ______________________________ **DOB:** ________________________________

<u>CURRENT MEDICATION ORDERS</u> – Please review medication list with participant's family during office visit for CCADS to have most comprehensive medication list on file.

***** If providing an additional medication list, please sign and date it, and state "See Attached" below or MD sign and date medication list provided.**

Date Rx	Medication	Strength	Dosage	Frequency	Route	Prescribing MD

***** Reminder, for care coordination, please notify family/caregiver, if making any changes in medications, diet orders, or blood sugar checks. CCADS is not a residential facility therefore communication with the participant's family is imperative. *****

__________________ ________________________________

Date **Signature of Physician**

Name of Physician: ____

Address: ____

Phone: _________________________ **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 _______________

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