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 Current Health Problems: _____

_____

Significant Past 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

Patient's name: _____ DOB: _____

STANDING ORDERS

Please choose all appropriate options

Diet:

- ☐ **Regular (our regular diet is diabetic and cardiac friendly)**
- ☐ **Other: _____**

Consistency: ☐ Regular ☐ Chopped ☐ Pureed (all meats are cut to bite size)

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 6 hours PRN musculoskeletal pain, headache, and/or fever.

☐ Ibuprofen 200mg tablet, 2 tablets PO every 6 hours PRN musculoskeletal pain, headache, and/or fever.

☐ 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).

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: _____

If Patient has Advance Directive or Durable Do Not Resuscitate, please provide copy

CURRENT MEDICATION ORDERS – 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**

_____ _____

Date **Signature of Physician**

Name of Physician: _____

Address: _____

Phone: _____ **Fax:** _____

REPORT OF TUBERCULOSIS SCREENING

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

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 _____