Patient Name: ____ DOB: _____________.

Daybreak - Adult Day Health Care Program
321 S. 15th Avenue – Yuma, Arizona 85364-4569
Telephone (928)783-8316 –Fax (928) 783-8317

Date: ______________________

Dear Physician,

This Patient is requesting to start services at Daybreak – Adult Day Health Care Program. In order for this Patient to initiate services from Daybreak, we require annual Physician's orders to be on file.

Additionally, new MD Orders will:
1) Assure that Daybreak is in compliance with State regulations;
2) Assist in providing quality care for the identified Patient.

Please complete the attached forms and return to us by mail or fax the MD Orders as soon as possible. If you have any questions, please call our office at 928-783-8316 between the hours of 8am – 4pm, Monday through Friday.

Thank you in advance for your attention in this matter.

Sincerely,

Marian Leon, RN MPH

Patient Name: ________________________________ DOB: __________.

Daybreak Adult Day Health Care Program
321 S. 15th Avenue – Yuma, Arizona 85364-4569
Telephone (928)783-8316 –Fax (928) 783-8317

PHYSICIAN STANDING ORDERS

Patient Name: ____________________________ DOB: ______________

Physician Name: ____________________________

ORDERS:

Please specify the applicable care and treatment

May have acetaminophen 500-1000mg PO q4hrs PRN __________

May have Antacid /calcium carbonate 750mg tab PO q2hrs PRN __________

In the event the following vaccinations can be provided, please specify the applicable vaccinations the Patient may obtain.

May receive annual flu vaccine IM __________

May receive pneumonia vaccine IM (once only) __________

The above order is as I gave it and is effective for one year.

____

Physician Printed Name, Credentials

____ ______________

Physician Signature, Credentials Date

PLEASE SIGN AND RETURN WITHIN 48 HOURS. THANK YOU!

For Daybreak Administration Use Only

Orders received at Daybreak:

Date: ____________________ Time: __________ ☐ AM ☐ PM

____

Nurse Signature, Credentials

Patient Name: ______________________________________ DOB: ____________.

In order for us to provide quality care at Daybreak – Adult Day Health Care Center, the standing orders need to specify parameters for vital signs and blood sugar testing for this Patient.

Please **complete** the Patient's Normal Limits and intervention requirements below.

Patient's Vital Signs			
	Patient's Normal Limits	**If below Patient's Normal Limits**	**If above Patient's Normal Limits**
BP		**Call MD**	**Call MD**
P		**Call MD**	**Call MD**
R		**Call MD**	**Call MD**
T		**Call MD**	**Call MD**

Blood Sugar			
	Patient's Normal Limits	**If below Normal Limits**	**If above Normal Limits**
Blood Sugar		**Call MD**	**Call MD**

Blood sugars to be checked: ______________________________________

______________________________________ ____________

Physician Signature, Credentials Date

Weight at Last Visit ______________ Date of Visit: ____________________

Vitals are checked at least two times a month. Does the Patient require the vitals to be done more frequently r/t medications? □ No

□ Yes, specify: ____

Patient Name: ____ DOB: _____________.

Diagnosis

Hematologic/Oncologic: ☐ **N/A**

☐ Anemia ☐ Cancer: ____________________ ☐ Leukemia ☐ Other: __________________________

☐Other: ______________________________

Cardiovascular: ☐ **N/A**

☐ Congestive Heart Failure ☐ Hypertension ☐ Other: ___________________________

Musculoskeletal: ☐ **N/A**

☐ Arthritis ☐ Degenerative Joint Disease ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Paralysis

☐ Other: ____________________________________ ☐ Other: ______________________________

Respiratory: ☐ **N/A**

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Emphysema

☐ Other: ____________________________________

Neurological: ☐ **N/A**

☐ Seizure Disorder* ☐ Cerebral Palsy ☐ Autism ☐ Mental Retardation ☐ Alzheimer's Disease

☐ Dementia ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Other: ____________________________

☐ Other: ____________________________________ ☐ Other: ______________________________

***For clients with a Hx of seizures, please specify parameters:**

☐ ***Single Seizure:*** 3-5 minutes duration- to be documented and caregiver notified. Seizures in excess of 5 minutes require emergency response.

☐ ***Multiple seizures:*** 10-15 minutes duration- requires documentation and caregiver notified. If any single seizure within the series exceeds the 5 minutes it requires emergency response. A new series begins and is identified by a lapse of any seizure activity for a period of 5 minutes.

☐ ***Other Parameters:***

____

____

Approved, Physician's Initials ____________ Not Approved, Physician's Initials ______________

Genital/Urinary: ☐ **N/A**

☐ Chronic Renal Failure/Insufficiency ☐ Urinary Retention ☐ Other: ___________________________

Gastrointestinal: ☐ **N/A**

☐ Ulcers ☐ Colitis ☐ Cirrhosis ☐ Constipation ☐ Other: ______________________________

Metabolic: ☐ **N/A**

☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other: ____________________________

Sight/Hearing: ☐ **N/A**

☐ Blindness ☐ Cataract ☐ Hearing Deficit ☐ Glaucoma ☐ Other: ______________________________

Other:

☐ Reduced Physical Stamina ☐ Birth Defect ☐ Fibromyalgia ☐ Other: __________________________

☐ Other: ______________________________ ☐ Other: ____________________________________

Allergies

☐ **NKA In all Allergies**

☐ Other: ____

____

____

Patient Name: ____ DOB: _____________.

Tuberculosis Screening

Form of Testing:

☐ Date of Last PPD Skin Test: _____________ ☐ Chest X-Ray: ______________

Result: ____

The Patient free of TB _________________
Physician's Initials

Current Medications

- Medications are provided at Daybreak between the hours of 1100 - 1330.
- Please specify below the medications the Patient is currently taking and what medications are expected to be provided at Daybreak.
- If the Patient requires a specific timeframe, please specify in the column.

Name-Dosage-Frequency-Route	Medications to be Provided at Daybreak	Specify Other Timeframe
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

☐ Additional Page of the list of medications is attached.

Can this Patient self-medicate with supervision? ☐ Yes ☐ No

Diet

Daybreak provides a no salt added diet.

Does the Patient have any dietary restrictions? ☐ Yes ☐ No

If yes, please specify: ____

____

Patient Name: ____ DOB: _____________.

Exercise

Can this client participate in the following activities?
Seated ROM: □ Yes □ No Adapted Sports: □ Yes □ No
Are there any restrictions or special activities this client needs to follow? □ Yes □ No
If yes, please specify: ____

____

Independence

Can this Patient sign in and out of the center? □ Yes □ No

Does the Patient have a Living Will? □ Yes □ No

Does the Patient have a Do Not Resuscitate Order? □ Yes □ No

Does the Patient have an Advanced Health Directive? □ Yes □ No

Does the Patient have a Medical Power of Attorney?

□ Yes, specify: ____ □ No

THIS INFORMATION WILL BE CONSIDERED CURRENT AND IN EFFECT FOR ONE YEAR FROM THIS DATE. IF THERE ARE ANY CHANGES, PLEASE NOTIFY DAYBREAK IN WRITING WITH SUCH CHANGES.

I have thoroughly examined _____________________________________ and he/she
Patient's Full Name
may enter into the activities offered by Daybreak Adult Day Health Care Center.

Physician's Signature, Credentials: ____

Printed Name: ____

Date: _____________ Phone #: ______________________ Fax #: ________________

Patient Name: ____ DOB: _____________.

Medical History Addendum

In order for Daybreak to have a record of their Health History, please complete the following form or attach your own copy of the Patient's Health History. Thank you.

☐ Physician's Office Copy of Health History is attached.

____ ________________________

Physician's Signature, Credentials Date

Please complete if, only if the Physician's Office Copy of the Patient's Health History is not attached.

Hematologic/Oncologic: ☐ **N/A**

☐ Anemia ☐ Cancer: __________________ ☐ Leukemia ☐ Other: _______________________

☐Other: ____________________________

Cardiovascular: ☐ **N/A**

☐ Congestive Heart Failure ☐ Hypertension ☐ Pacemaker ☐ Other: ________________________

Musculoskeletal: ☐ **N/A**

☐ Amputation ☐ Arthritis ☐ Degenerative Joint Disease ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Paralysis

☐ Joint Replacement ☐ Curvature of Spine ☐ Other: _______________________________

☐ Other: __________________________________

Respiratory: ☐ **N/A**

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Emphysema

☐ Other: __________________________________

Neurological: ☐ **N/A**

☐ Seizure Disorder ☐ Cerebral Palsy ☐ Autism ☐ Mental Retardation ☐ Alzheimer's Disease

☐ Dementia ☐ Parkinson's Disease ☐ Stroke ☐ Multiple Sclerosis ☐ Other: ___________________

☐ Other: __________________________________ ☐ Other: ___________________________

Genital/Urinary: ☐ **N/A**

☐ Chronic Urinary Tract Infection ☐ Chronic Renal Failure/Insufficiency ☐ Urinary Retention

☐ Other: ____________________________

Gastrointestinal: ☐ **N/A**

☐ Ulcers ☐ Colitis ☐ Irritable Bowel Syndrome ☐ Cirrhosis ☐ Constipation ☐ Other: _____________

Metabolic: ☐ **N/A**

☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other: _________________________

Sight/Hearing: ☐ **N/A**

☐ Blindness ☐ Cataract ☐ Hearing Deficit ☐ Glaucoma ☐ Other: ___________________________

Other:

☐ Fibromyalgia ☐ Other: ______________________ ☐ Other: ___________________________ ☐ Other: ______________________________

____ ________________________

Physician's Signature, Credentials Date