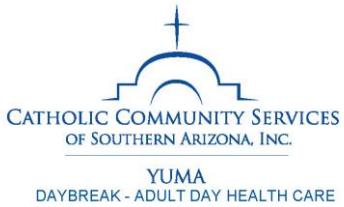
Patient Name:_____DOB: _____



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

Date: _____

Dear Healthcare Provider,

_____ is requesting to start/continue services at Daybreak – Adult Day Health Care Program. In order for _____ to start/continue services at Daybreak, we require a provider's Standing Orders to be on file. Standing Orders ensure that Daybreak is in compliance with state regulations as well assist in providing quality care for the identified participant.

Please note, a TB skin test is no longer required on an annual basis, but an initial PCP assessment with a one time Mantoux skin test or QuantiFERON Gold blood test with result is required to continue attending Daybreak. The TB screening will then be performed annually in conjunction with standing orders.. Chest X-rays are no longer an acceptable diagnostic test.

Please complete the attached Standing Orders form and return to us by fax at 928-783-8317. If you have any questions, please call Daybreak at 928-783-8316 between the hours of 8am – 4pm, Monday through Friday. Thank you in advance for your attention to this matter.

Sincerely,

Daybreak- Adult Day Health Care Administrator

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

STANDING ORDERS

Patient Name: _____ DOB: _____

PCP Name: _____

List of all Diagnoses:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies:

□ **NKA**
□ Other: _____

Recent Hospitalizations/Rehabilitation Admission:
Dates Admission_____ Discharge _____
Facility_____

Tuberculosis Screening:
□ Date of Last PPD Skin Test: _____□ QuantiFERON Gold: _____
Result: _____Free of TB _____
Provider's Initials_____

(please complete, sign, and return the Initial TB screening and Risk assessment form)

Patient Name:_____DOB: _____

Initial Integrated Tuberculosis (TB) Screening and Risk Assessment Form for Daybreak Participant

Name: _____ **Date**:_____

Preferred Contact Information: _____

1. Has the participant EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.
    a. YES I have been in a foreign country for ≥30 days **(not including those listed above)**
    b. NO I have not been in any country for ≥30 days **except the ones listed above**

2. Has the participant had close contact with anyone who had active TB since your last TB test?
    YES / NO

3. Does the participant currently have any of the following symptoms:
    a. YES / NO unexplained fever for more than 3 weeks
    b. YES / NO cough for more than 3 weeks with sputum production
    c. YES / NO bloody sputum
    d. YES / NO unintended weight loss >10 pounds
    e. YES / NO drenching night sweats
    f. YES / NO unexplained fatigue for more than 3 weeks

4. Has the participant ever been diagnosed with active TB disease?
    YES / NO

5. Has the participant ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?
    a. YES one or more of these is true for me
    b. NO none of these is true for me

6. Has the participant been treated with medication for TB *or* for a positive TB test (eg, taken "INH")?
    YES / NO
    If YES, what year, with which medication, for how long, and did you complete the treatment course?
    _____

7. Does the participant have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider)
    a. YES, one or more of these is true for me
    b. NO, none of these is true for me

_____ _____
PCP Reviewer Signature Date

Patient Name:_____DOB: _____

Orders

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

Weight and Vital signs monthly unless otherwise stated _____

Blood sugar Testing (Diabetics) _____

Other Treatments/Monitoring _____

Weight at Last Visit _____ Date of Visit: _____

Please **complete** the Patient's normal limits and intervention requirements below.

Vital Signs			
	Normal Limits	**If below Normal Limits**	**If above Normal Limits**
BP		**Call Provider**	**Call Provider**
P		**Call Provider**	**Call Provider**
R		**Call Provider**	**Call Provider**
T		**Call Provider**	**Call Provider**

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

Patient Name:_____DOB: _____

Please specify the applicable care and treatment

May have the following on a PRN basis:

Acetaminophen 500-1000mg by mouth every 4hrs PRN YES_____ NO_____

Antacid /calcium carbonate 750mg tab by mouth every 2hrs PRN YES_____ NO_____

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) _____

Current Medications

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
	□ 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 medication page is attached.**

Patient Name:_____DOB: _____

Diet

Daybreak provides a no salt added diet.

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

If yes, please specify: _____

_____

Exercise

Can this patient 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

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

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

Patient Name:_____DOB: _____

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

□ **Provider's Office Copy of Health History is attached.**

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

Hematologic/Oncologic: □ **N/A**
□ Anemia □ Cancer: _____ □ Leukemia □ 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 □ Developmental Disability □ Alzheimer's Disease
□ Dementia □ Parkinson's Disease □ Stroke □ Multiple Sclerosis □ 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: _____

Patient Name:_____DOB: _____

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.

The above orders are as I gave and are effective for one year.

Healthcare Provider's Signature, Credentials: _____

Printed Name: _____

Date: _____ Phone #: _____ Fax #: _____

PLEASE SIGN AND RETURN WITHIN 48 HOURS. THANK YOU!

For Daybreak Administration Use Only

Orders received at Daybreak:

Date: _____ Time: _____ □ AM □ PM

_____
Nurse Signature