Dear Healthcare Provider,

(Name) is requesting to start services at Daybreak – Adult Day Health Care Program. In order for (Name) to start 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 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 in this matter.

Sincerely,

Ann Farley RN

Daybreak- Adult Day Health Care Administrator
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: ___________  □ Chest X-Ray: ___________
Result: ________________________________ Free of TB ___________
Provider’s Initials ________________
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.

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>Normal Limits</th>
<th>If below Normal Limits</th>
<th>If above Normal Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td></td>
<td>Call Provider</td>
<td>Call Provider</td>
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<td>P</td>
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<td>Call Provider</td>
<td>Call Provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Sugar</th>
<th>Patient’s Normal Limits</th>
<th>If below Normal Limits</th>
<th>If above Normal Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Sugar</td>
<td></td>
<td>Call Provider</td>
<td>Call Provider</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Name-Dosage-Frequency-Route</th>
<th>Medications to be Provided at Daybreak</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td></td>
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<tr>
<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

Additional medication page is attached.
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
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: ____________________________
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
Tuberculosis (TB) SCREENING

Please complete applicable section(s). For example: if client has a negative skin test, please fill out PPD section. If client has a positive skin test, client will need a chest x-ray for the initial positive result and a survey only every year thereafter. Chest x-rays may be done when results are negative or positive on a yearly basis but will result in unnecessary exposure to radiation.

**PPD:** □ Positive, __ mm or □ Negative, no evidence of TB
Date Given: Date Read:

***Please Attach Results □
Lot #: Expiration Date:

Health Care Provider Printed Name/Credentials Signature

**X-Ray:** □ Positive or □ Negative, no evidence of TB
Date:

***Please Attach Results □
Comments:

Health Care Provider Printed Name/Credentials Signature

**Clearance Survey:** □ Positive or □ Negative, no evidence of TB
Date:

***Please Attach Results □
Comments:

Health Care Provider Printed Name/Credentials Signature