Medical Assessment

Client Name: _____ Date of Birth: _____

The above-named person is being evaluated for services with Adult Life Programs (ALP), a provider of day services for the elderly, and adults Intellectual-Developmental Disabilities or mental health needs. Services are monitored by the NC Department of Health & Human Services, and Division of Aging and Adult Services. Medical information is necessary to ensure appropriate care and provision of services to individuals we support.

Please indicate if client has been diagnosed and/or is being treated for any of the following diseases or conditions and indicate if special attention or activity restrictions are required.

Diagnosis	ICD-10 Code	Notes
Primary Dx:		

Vital Signs		Tuberculosis	
Height:	Weight:	Most Recent Result (if applicable):	
Blood Pressure:	Pulse:	Date Read:	
Flu Vaccine		**COVID Vaccine**	
Date Given:	Refused:	First Dose:	Refused:
Allergy to Vaccine:		Second Dose:	Booster:

Chronic Disease/Condition	Yes	Special Attention or Device	Activity Restrictions
Anemia			
Arthritis			
Artificial Joint/Limb			
Asthma			
Blindness			
Blood Pressure Disorder			
Bowel/Stomach Problems			
Cerebral Palsy			
Dentures			
Diabetes			
Emphysema/ Chronic Bronchitis			
Epilepsy/Seizures			
Fainting Spells			
Heart Disease/Disorder			

Hearing Problems			
Kidney Disease			
Liver Disease			
Lung Disorder			
Neurological Disorder / Migraines			
Skin Disorders			
Stroke/Effects of Stroke			
Tuberculosis			
Ulcers			
Urinary Tract Problems			
Intellectual/Developmental Disability			
Psychiatric Disorder/Illness			
History of Self Harm			
History of Aggression			

Allergies or reactions to medication or substances:
Does client use adaptive equipment (walker, cane, hearing aids, wheelchair, etc.) OR have any implants or devices (Pacemaker, Vagal Nerve Stimulator, etc.)?
Is client currently receiving ongoing medical treatments?
Current or prior history of psychiatric illness, treatment, or hospitalization:
Is supervision necessary to ensure client doesn't harm shelf, others, or property?
Will client wander off is not closely monitored?
Recommended restriction on psychical activities such as walking, exercise, etc.:
Describe any need for physical therapy:
Does client require a special diet (please describe or attach copy)?
Other comments, needs, or concerns not address above:

Please List All Prescriptions, Vitamins/Supplements, and Over the Counter Medications
(If No Medications, Write N/A)

Medication	Dosage	Instructions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

I certify that today I have reviewed the health history and examined this person and find him/her physically able to participate in Adult Life Programs, an adult day activity program.

_____

Signed (Licensed Physician, Physician Assistant, or Nurse Practitioner) Date

_____

Address

Telephone Number: _____

Date Client was Last Seen by a Medical Provider: _____

Standing Orders

Client Name:	Date of Birth:

A Physician/Nurse Practitioner signature is needed to authorize administration of PRN non-prescription medications that are kept on hand at Adult Life Programs. Check the box next to the non-prescription medication that you would like for the participant to take as needed while attending Adult Life Programs. **Adult Life Programs is required to obtain yearly authorization for Standing Orders for each participant.**

▪ **Acetaminophen (Tylenol)** 500mg 1 tablet every four hours by mouth PRN pain.
▪ **Acetaminophen (Tylenol)** 500mg 2 tablet every four hours by mouth PRN temperature >100 degrees.
▪ **Robitussin (Guaifenesin syrup)** 10cc (2 teaspoons) every four hours by mouth PRN chest congestion.
▪ **Robitussin DM (Tussin DM)** 10cc (2 teaspoons) every four hours by mouth PRN cough with chest congestion.
▪ **Diabetic Tussin** 10 CC (2 teaspoons) every four hours by mouth PRN cough with chest congestion.
▪ **Mylanta (Antacid**) 20cc (4 teaspoons) between meals by mouth PRN indigestion**/**heartburn; not to exceed 60cc (12 tsp in a 24 hour period).
▪ **Imodium Loperamide Hydrochloride (Imodium)** 2MG (2 caplets) after the first loose stool. (1 caplet) after each subsequent loose stool by mouth PRN **diarrhea**; no more than 4 caplets in 24 hours.
▪ **Milk of Magnesia** 30cc (2 tablespoons) with 8 ounces of water once a day by mouth PRN constipation.
▪ **Famotidine (generic Pepcid / Zantac)** 20mg by mouth one dose with **Diphenhydramine (Benadryl)** 25mg PO for allergic reaction. **Notify Primary Care Physician and call 911 if any signs or symptoms of anaphylactic reaction.**
▪ **Hydrocortisone cream 1%** for rash/itching apply to the affected PRN, no more than 3 to 4 times a day.
▪ **Difficulty swallowing medications;** crush pills if crushable or give medication whole in applesauce or pudding.
▪ **Pulse oximetry PRN** for shortness of breath/respiratory distress. Call 911; notify physician <90.
▪ **Fingerstick blood sugar PRN** for signs and symptoms of hypoglycemia/hyperglycemia. Notify the physician.
▪ **Sunscreen/Sun block**
▪ **Triple Antibiotic Ointment** to be applied for minor skin abrasion

Physician/Physician Assistant/Nurse Practitioner Signature **Date**