

Date of Request		Physician	
Phone #		Fax #	
Participant's Name		Participant's DOB	

Medical Questionnaire and Standing Orders Form

Allergies list provided _____

Dietary Needs: Diabetic Regular No added Salt Low Fat No added sugar
 No raw fruits or veggies Other _____

Dysphagia: Yes No **Requires food:** Chopped Pureed

Thickened Liquids: Yes No (Nectar Honey Pudding)

Hearing: Normal Impaired Deaf Requires Hearing Aid Other: _____

Vision: Normal Requires Glasses Impaired Vision Legally Blind Other: _____

Ambulation: Independent Wheelchair Uses Walker Uses Cane Other _____

Incontinence: Bowel Yes No Bladder Yes No

List all primary diagnosis and current medications below or attach list:

DIAGNOSIS	MEDICATION NAMES	DOSAGE	FREQUENCY

Is SarahCare Nurse able to administer (OTC) Over-The-Counter products. Please Check YES or NO		
Tylenol 325 mg. 1 or 2 tablets every 4 hours as needed for pain or fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ibuprofen 200 mg. 1 or 2 tablets every 4 hours as needed for pain or fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Maalox 30cc every 4 hours as needed for stomach upset	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Imodium 2mg once daily as needed for sudden diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
OTC Cough Drop every 2 hours as needed for cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
OTC Cough Suppressant Liquid every 4 hours as needed for cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tums 1 or 2 tablets every 4 hours as needed for indigestion/heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No
May check blood sugar with finger stick testing unit as needed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Minor wound care as needed; cleanse w/ normal saline; apply triple antibiotic & dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Preliminary urine dipstick test for RBCs, WBCs, and Nitrates for s/s of UTI	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(MOM) Milk of Magnesia for constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Physician's signature: _____

Physician's Printed Name: _____ Date: _____

SarahCare of Coral Springs

Adult Day Care Center | License #9070
754 Riverside Drive, Coral Springs, FL 33071 | (954) 743-0003

REQUIRED

FREE FROM COMMUNICABLE DISEASE STATEMENT

DATE: _____

I, _____, a Florida licensed
physician/Nurse Practitioner/Physician Assistant, do hereby, on the above date certify
that _____
is free and clear from Tuberculosis in the communicable form, and free from signs and
symptoms of any other communicable disease.

Physician's / Provider's Signature

Date