

Date \_\_\_\_\_

To: Dr: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Adult Day Health**

## PHYSICIAN ORDER REQUEST

Participants Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Your patient has applied or is receiving Adult Day Health Services. Signed orders from you are needed to provide the following services as part of your patient's CarePlan. CarePlan goals/orders will be reviewed by Adult Day Health staff quarterly and sent to you for review and initials.

**REQUESTED BY:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

### NURSING SERVICES:

1. Your client has agreed to schedule a physician office visit every \_\_\_\_\_ months.
2. Initial and on-going nursing assessment to develop Careplan and adjust PRN.
3. In the event of an emergency, O2 saturation via pulse oximetry and BSL may be checked as part of assessment process. For O2 status of 99% or below and BSL's below 0 or above 400, nurses will contact you and 911 emergency services as needed.
4. These over-the-counter (OTC) medications will be administered on an "As Needed" basis for the reason indicated. Unless contraindicated by you (strike out each contraindicated OTC).
  - a. **Acetaminophen 325mg** 1-2 tabs q4-6hrs as needed for general pain/headache
  - b. **AIOH/MgOH** antacid (Maalox, Mylanta) 2tsp TID as needed for c/o heartburn, indigestion
  - c. **Calcium Carbonate** (Tums) 1-2 tab TID as needed for c/o heartburn, indigestion
  - d. **Topical Triple Antibiotic** ointment for superficial abrasions
  - e. **Moisture Barrier Cream as needed** to protect from skin irritation
  - f. **Sun Screen** for topical application for outings

### OCCUPATIONAL THERAPY SERVICES:

1. Initial and on-going screening and evaluation by OTR to develop OT treatment plan (which will be sent to you for approval) and adjust PRN.

### PHYSICIAN COMMENTS/ORDERS:

Physician Initials: \_\_\_\_\_

Date: \_\_\_\_\_

Please contact \_\_\_\_\_ at (253) 403-1188 if you have any questions or concerns. Signed orders can be faxed to (253) 473-3117. Thank you.