ABILITY FIRST ADULT DAY CENTER
2115 Beech Street Duncan, OK 73533
FAX 580-252-3370

Physician's Orders

Please ask your physician to complete the following information for Ability First Adult Day Center, as part of programming requirements for the Oklahoma Department of Health.

Participant: _____
FIRST MI LAST
Date of birth: _____

1) Date of last physical assessment: _____

2) List of all diagnoses: 1) _____ 2) _____
3) _____ 4) _____
5) _____ 6) _____
7) _____ 8) _____

3) Weight and vital signs taken once every month unless otherwise stated:
_____

4) **A**. Is patient diabetic? (If no, skip to next question: ☐ Y ☐ N

B. Test blood sugar once every month unless otherwise stated: _____

5) Other treatments including oxygen or breathing treatments: _____

6) Is there a DNR order: ☐ Y ☐ N
7) Allergies to Medications or Foods: _____
8) Medications including OTC meds (please include dosage and frequency):
1) _____ 8) _____
2) _____ 9) _____
3) _____ 10) _____
4) _____ 11) _____
5) _____ 12) _____
6) _____ 13) _____
7) _____ 14) _____
9) Patient may have any of the following on a prn basis (please check):
☐ Tylenol 500 mg ☐ Tums antacid ☐ Other (please specify)

10) Dietary needs (please check one):
☐ General or Regular diet ☐ General Diabetic diet ☐ Sodium Restricted diet

ABILITY FIRST ADULT DAY CENTER
2115 Beech Street Duncan, OK 73533
FAX 580-252-3370

☐ Other (include any food or fluid restrictions): _____

11) Patient may receive wound care with soap and water for cuts and scrapes? ☐ Y ☐ N

12) **A**. Patient may participate in group chair exercises? ☐ Y ☐ N
B. Activity level: _____

13) Seizure Protocol:

☐ Not Applicable

☐ Call 911 if a seizure lasts over ____ minutes.

☐ Call 911 if has more than _____ seizures in _____ minutes.

Please note: Ability First Adult Day Center will automatically make contact with responsible person after seizure and after calling for emergency services when necessary.

14) Special Instructions:

_____

_____

_____

_____

_____

_____

Physician's Printed Name: _____

Phone: _____ Fax: _____Email:_____

Address: _____City_____State_____

Date: _____ Signature of physician: _____