

MEDICAL EVALUATION (page 2)

NAME: _____

Is the individual:

Free of communicable disease? Yes No. If no, describe: _____

Able to transfer without assistance? Yes No. If no, describe: _____

Ambulatory without assistance? Yes No. If no, describe: _____

Describe Activity Restrictions/Assistance Needed with ADLs (e.g. eating, transferring, toileting):

Describe Current Treatment Plan (e.g., nursing, therapies, labs, etc.):

Is the individual's condition stable? Yes No. If no, describe: _____

Does the individual have a history, current condition or recent or current hospitalization for mental disability?

Yes No. If yes, describe: _____

Is a Mental Health Evaluation recommended? Yes No

Date of Today's Examination: _____ Recommended Frequency of Medical Exams: _____

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared in an adult home, enriched housing program or an ALP.

Signature: _____ Date: _____

Nurse Practitioner, Physician's or Specialist's Assistant

Signature: _____ Date: _____

Physician (required)

**MEDICAL EVALUATION ADDENDUM
PPHA STANDING ORDERS FOR OVER THE COUNTER MEDICATION
DIETARY POLICY**

RESIDENT: _____

OVER THE COUNTER PRN MEDICATIONS:

- Tylenol, 325mg 2 tabs, po q 4hrs PRN (pain/fever)
- Mylanta, 30cc, po q 4hrs PRN (indigestion)
- Tums, 2 tabs po PRN, as directed on label (indigestion)
- Milk Of Magnesia, 30cc po PRN as directed on label (constipation)
- Robitussin Cough Syrup, 10cc po PRN as directed on label
- Neosporin Ointment, topically PRN minor skin irritation
- Kaopectate, 30cc po PRN as directed on label (diarrhea)
- Imodium AD, 2 caps or 10cc after each loose BM, as directed on label (diarrhea)

** If you expect your patient to use any of these medications on a regular basis, i.e. Tylenol, please write a separate prescription so that they may have their own supply. If any variations in the above orders, please list below. Thank you.

May have alcoholic beverages. YES NO

May have regular diet on special occasions. YES NO

Physician Signature: _____

Date: _____