THE RETREAT
A SENIOR DAY EXPERIENCE

Council on Aging of West Florida, Inc.

COUNCIL ON AGING OF WEST FLORIDA, INC. EST. 1972

PHYSICIAN'S ADMISSION ORDER SHEET

Adult Day Health Care Center
875 Royce Street/Pensacola, FL 32503
Phone: 850-266-2503/Fax: 850-479-9075
e-mail: jayers@coawfla.org / web:www.coawfla.org

Please complete this form in its entirety

Patient Name:	SS#:
Diagnosis:	
Caregiver Name:	Caregiver Phone
Physician Name:	Physician Phone
Diet: □ Regular (Low Salt, Low Fat) □ **No Milk, Lactose Intolerant Substitute 8oz. Juice or Water** □ Modified (No concentrated sweets)	
Allergies:	
Medications & Frequency of Administration (Routine, PRN, and Over the Counter Medication)	
May administer Tylenol 325 mg. 1-2 tabs PO for headache or pain Q 6 hours PRN	
Medication to be: □ Self-administered □ Supervised □ Administered	
Date of Last Chest X-ray & Result **OR** Date of last TB Skin Test & Result **(must be within last 45 days)**	
Communicable Disease: □Yes □No If yes, please explain:	
Date and Results of Urinalysis (must be within last 6 months)	

Rehabilitation Potential: □ Good □ Fair □ Poor	Therapy Recommendation: □ OT □ PT □ Speech	Recommended Frequency of Visit to Physician:
Therapy Assessment/Treatment Recommendations for: □ Gait Training □ Extremity Strengthening □ ADL Training		
Does client have a completed DNR form? □ Yes □ No If yes, please attach copy.		
Physician's Signature	**Date**	