Council on Aging of West Florida, Inc.

PHYSICIAN'S ADMISSION ORDER SHEET

Council on Aging Adult Day Health Care Center
875 Royce Street
Pensacola, FL 32503
Phone: (850) 432-1475 Fax: (850) 479-9075

Please complete this form in its entirety

Patient Name:	**SS#:**
Caregiver Name:	**Caregiver Phone:**
Diagnosis:	**Physician Name:**
	Physician Phone #:
Allergies:	**Diet: _ Regular (Low Salt, Low Fat)** **_ Modified (No conc. Sweets)**

Medications & Frequency of Administration (Routine, PRN and Over the Counter Medications)
Medication to be: _ Self-administered _ Supervised _ Administered
May return to day care (applicable following extended absence) _ Yes _ No
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**	**Rec. Frequency of Visit to Physician:**
Therapy Assessment / Treatment Recommendations For: _ Gait Training _ Extremity Strengthening _ ADL Training		
Other:		
Recommended Attendance to adult day health care (Medicaid minimum is 3 days per week)		

Physician's Signature	**Date**