

Sirriner Adult Day Health Services, Inc.
Health Review Form

Sirrine Town Center
247 N. MacDonald
Mesa, AZ 85201
Tel: 480-464-1061
Fax: 480-464-1166

Sirrine Red Mountain
7550 E. Adobe
Mesa, AZ 85207
Tel: 480-641-7644
Fax: 480-641-1486

Patient Name _____ Male Female

Age: _____ **DOB** _____ **Height:** _____ **Weight:** _____ **BP** _____

Attending Physician _____
(Please Print Name)

Diagnosis: _____

Medical/Surgical History: _____

Allergies: (NKDA) _____

Food Allergies: (NKFA) _____

ABLE TO BEAR WEIGHT AND ASSIST IN TRANSFERRING YES NO

If TB skin test (PPD) is read positive, a chest X-ray must be done and state no evidence of TB in report. This must be done before a person is admitted to Sirrine Adult Day Care.

PPD or CXR RESULTS (Negative test required within last 6 months prior to Sirrine attendance)

Date of PPD Test _____ **Results:** Negative Positive

Date of CXR Test _____ **Results:** Negative Positive

FREE OF COMMUNICABLE DISEASE: Yes No

GENERAL PHYSICAL CONDITION: Excellent Good Fair Poor

ORIENTATION: Alert Mildly Confused Moderately Confused Severely Confused

DIET: Regular Diabetic Low K Diet

Regular Diet OK for Special Occasions: Yes No

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STANDING ORDERS:

ROM as tolerated with exercise program: Yes No Other: _____

LIMITATIONS / RESTRICTIONS / SPECIAL NEEDS:

<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Visual	<input type="checkbox"/> Toileting
<input type="checkbox"/> Walker	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Transferring
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Dental	<input type="checkbox"/> Physical
<input type="checkbox"/> Crutches	<input type="checkbox"/> Auditory	<input type="checkbox"/> Other

CURRENT MEDICATIONS:

RX: _____	RX: _____
RX: _____	RX: _____
RX: _____	RX: _____
RX: _____	RX: _____
RX: _____	RX: _____
RX: _____	RX: _____
RX: _____	RX: _____

Over the Counter Medications: Please check if the Nurse can provide the following PRN medications.

Tylenol ES Tabs or Liquid i-ii q 4 hrs.	PRN Discomfort	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ibuprofen 200 mg. Tabs i-ii q 4 hrs.	PRN Discomfort	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kaopectate (as directions)	PRN Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pepto-Bismol (30 ml as directions)	PRN Indigestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tums EX (as directions)	PRN Antacid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Maalox or Mylanta (as directions)	PRN Antacid/Gas	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Milk of Magnesia (30 ml q day)	PRN Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neosporin Ointment (as directions)	PRN Minor Skin Tears	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other: _____

Physician Signature: _____ **Date of Exam:** _____

Tel: _____
Fax: _____
Address: _____

I hereby authorize release of information relevant to this request:

Client Signature or Responsible Party	Relationship	Date
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