Eastern Oklahoma County Technology Center
Adult Day Services
4601 N. Choctaw Road
Choctaw, Oklahoma 73020
Phone: (405) 390-4400 Fax: (405)390-6637

Re: _____ Date: _____

Dear Physician:

Enclosed please find a copy of Physicians Orders from Eastern Oklahoma County Technology (EOC) Adult Day Center. Although we are not a nursing facility providing 24 hour care, we do provide medical supervision of our participant's needs while they are with us during the day. All participants must have their Physician's Orders to attend our center so we may formulate a complete care plan for each individual.

State Health Department Regulations for adult day services require that a physician must sign/co-sign all orders with a ARNP or a PA-C. It is acceptable for a ARNP or PA-C to complete the examination, but a physician must co-sign.

Please complete the attached orders specifically for your patient's needs, sign them and give to patient to bring to us. You may fax them back to us at (405) 390-6637 when completed if needed.

Sincerely,

Megan Hall, L.P.N.
Program Nurse
EOC Adult Day Center

(Revised 4/19/17)

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PHYSICAL EXAMINATION

Participant Name: _____ Date: _____

DOB: _____ SSN: _____

Ht: ____ft. ____ in. Wt. _____lbs. BP _____ P_____ Resp._____

Allergies: Medication: _____ Food: _____

MEDICAL DIAGNOSIS:

1. _____ 2. _____ 3. _____

4. _____ 5._____ 6. _____

TEETH: Own Teeth _____ Dentures: Y / N Upper __ Lower __

VISION: good ___ fair___ poor ___ Glasses: Y / N

HEARING: good ____ fair ____ poor ____ Hearing Aide: Y / N Right ___ Left ___

LUNGS: _____ **HEART**: _____

GI: _____ Constipation _____ Diarrhea _____ Incontinence _____

URINARY: _____ Chronic UTI _____ Incontinence _____

EXTREMITIES: _____Edema _____Skin Condition: _____

MENTAL STATUS:

Memory Loss: Y / N Short term: _____ Long term: _____

Dementia: Y / N Type _____ Stage _____

Depression: Y / N Anxiety _____ Other _____

Caregivers Name: _____

Caregivers Telephone #: _____**Cell #**:_____

Physician's Signature: _____ Date: _____

Participants Name: _____

CURRENT MEDICATIONS **Dosage** **Frequency**

_____

_____

_____

_____

Standing Orders:
_____ Tums, Antacid, Calcium Carbonate, 750 mg, 2 tabs PRN, for indigestion
_____ Tylenol 325 / 500 mg 1 or 2 tabs q 4-6 hrs PRN pain or elevated temp
_____ Imodium AD 1 caplet after each loose stool x2 PRN diarrhea
_____ OTC throat lozenges 1 for sore throat or cough PRN every hour x 3

If Diabetic—FSBS prn: yes____ no____ (Normal range:_____)

Date of last Influenza injection: _____

DIET: General/Regular: _____ Mechanical soft:_____ Pureed:_____

General/Regular with Limited Concentrated Sweets: _____

General/Regular with No Added Salt: _____

Chewing difficulties: Y / N Swallowing difficulties: Y / N

ACTIVITY LEVEL: Full _____ Limited _____ Explain _____ _____

Assistive Devices: _____Cane _____Walker _____Wheelchair _____Braces

Fall Risk: Y / N

Physician's Signature: _____ Date: _____

Print name: _____

Address: _____

Telephone _____ Fax _____
(Revised 4/19/17)

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Physician Medication Orders

THIS FORM IS FOR MEDICATIONS TO BE GIVEN AT THE ADULT DAY SERVICES CENTER *ONLY*

Name:_____ DOB:_____

SSN:_____

Medication Name	Dose	Route	Frequency/Time

*** Our facility is compliance with State Regulation, Title 310:605-13-2 from the Oklahoma State Department of Health.**

Physicians Printed Name: _____

Physicians Signature: _____ Date: _____

EOC Adult Day Services:
Program Nurse Signature: _____ Date:_____
(Revised 4/19/17)