James L. West Senior Day Program Physician's Orders

This form **must be completed** by the applicant's physician prior to admission in the Senior Day Program. Completed forms can be returned via email to hmacchietto@jameslwest.org or faxed to 817-877-1414.

Dear Physician:

The Senior Day Program at James L. West is designed for older adults who have a diagnosis of Alzheimer's disease or other dementias, or who exhibit symptoms of cognitive impairment that are not of acute onset related to another treatable medical condition.

Your patient _____ Date of Birth: _____
is applying to attend the day program. Please read through these criteria and keep it in mind as you certify that your patient is appropriate for our program.

Potential Applicants Should Be:

1. 60+ years of age and have a diagnosis of Alzheimer's Disease or other dementia, and/or exhibit signs of memory loss or cognitive decline which require mild-moderate assist and/or supervision.
2. Willing to attend the program, participate in and benefit from scheduled activities.
3. Able to function within a structured setting around other people with any displayed behaviors being manageable in our environment.
4. Able to follow basic directions and be able to make needs understood.
5. Able to ambulate independently or with the assistance of a wheelchair or walker, and able to safely assist with transfers.
6. Able to eat independently or with cueing and assistance the regular diet provided by the Center, or available modified diet(s) with a doctor's order.
7. Redirectable in his/her wandering and willing to remain in the secure area.
8. Able to use the bathroom independently *or* may have incontinence that is controlled by consistently and appropriately using protective undergarments. In such cases, the staff will assist with incontinence care as needed to include toileting reminders, assistance with changing protective undergarments, and adequate hygiene to prevent odor.
9. Not have health issues that are outside the scope of care provided in our setting or requiring acute medical intervention on an on-going basis.

Persons <u>who may not be eligible</u> for admission include persons who:

1. Are outside of our age criteria and/or would not fit in with our clientele of persons living with dementia.
2. Have skilled medical needs unable to be cared for by our staff.
3. Are unable to participate in mealtimes.
4. Are under the influence of or habitually addicted to alcohol and drugs and, due to the addiction are disruptive in a group setting.
5. Require a 2-person assist to transfer from wheelchair to chair and/or to/from toilet.
6. Require ongoing, extensive assistance with bladder or bowel incontinence, are combative or refuse needed assistance with toileting or refuse to wear needed protective undergarments.
7. Any person who poses a serious threat to the health, safety or well-being of the other participants or staff at the program.

   Physician's Initials _____

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Patient: _____Date: _____

Diagnosis: _____

Known allergies: _____

Diet Order: (please check appropriate boxes below)

☐ Regular ☐ No Concentrated Sweets ☐ No Added Salt ☐ Gluten Free

☐ Mechanical Soft ☐ Chopped

Most Recent: Blood Pressure _____ Pulse_____Weight_____

TB/Mantoux Skin Test Results: _____ (Required for admission)

Date administered _____ By whom/title_____

Date read_____ By whom/title _____

OR: The results of a chest x-ray _____ Date taken_____

I verify that to my knowledge this patient if free from communicable disease. Yes☐ No☐

Special instructions if patient has a communicable disease but may attend the adult day center:

_____

Is the patient combative? Yes ☐ No☐

Does the patient wander away from home or indicate a potential to wander? Yes☐ No☐

Does the patient use mobility aids? If so, what? _____

Is the patient able to transfer independently? Yes☐ No☐

Limitations? _____

Is the patient incontinent? Yes☐ No☐ Bladder ☐ Bowel ☐

May this patient take part in range of motion activities? Yes☐ No☐

Limitations? _____

Has this patient been declared incompetent? _____

I _____have thoroughly examined _____

on_____, read through the admission criteria, and believe that he/she appropriate for the James L. West Senior Day Program.

(Print or Type)

Physician's Name _____

Address _____

_____

Phone _____ Fax_____

_____ _____ _____

Physician's Signature Date NPI #

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Patient's Name _____

Note: Please include PRN and over the counter items

Complete Medication List

Required even if the patient will not take medications at the day program.

Name of Medication	Dosage	Times Given	Reason Given

Is this patient capable of self-administering medications? Yes☐ No ☐

Physician's permission for facility to:

Administer PRN Tylenol/Ibuprofen Yes ☐ No ☐
Administer PRN Tums/Mylanta Yes ☐ No ☐
Administer PRN Imodium Yes ☐ No ☐

Apply Sunscreen? Yes ☐ No ☐
Clip/File Fingernails? Yes ☐ No ☐

Physician's Signature: _____
Date: _____