PPCH
PARKER
PERSONAL
CARE
HOMES

Annual Physical Examination Form with PRN list

Client Name: **Physician Name:**

Date: **Office Address:**

DOB: **Office Phone and Fax:**

Physician: Please write notes / impressions on both pages.

General Appearance:

Vital Signs:

_____B/P _____Pulse _____Resp.

_____Temp.(F) _____Wt. (lbs) _____Ht .

Allergies:

Last Tetanus:_____ Flu vaccination:_____

Hepatitis B series:_____ Pneumovax:_____

TB test (PPD only/chest x-ray): ___Yes ___No

Test to be read on (date):_____/_____/_____

Consumer to return to your office for reading: _____Yes _____No

Labs drawn in this office today? _____Yes _____No If Yes, please specify:

How often are labs to be drawn? _____

HEENT

Hearing Evaluation:_____ Within Normal Limits?_____Yes _____No

Audiology Exam Recommended:_____Yes ____No

Chest/Lungs:

Cardiovascular:

GI/Abdomen:

Phys. Initial

Genitalia:

Gynecology Exam for Females:

PAP Smear Completed: _____Yes _____No Deferred Until: _____
Reason for Deferral:

Mammogram Ordered: _____Yes _____No Deferred Until: _____
Reason for Deferral:

STD Prevention Counseling Completed: _____Yes _____No ____N/A

Prostate cancer screening for Men: _____Yes _____No Deferred Until: _____

Skin (including Routine Foot Care):

Musculoskeletal:

Neurological:

Impressions:

Mobility Needs? Circle all that apply:

Walks Independently	Walks w/ standby assistance	Crutches	Walker	Gait belt	Electric W/C	Manual W/C

Mobility comments:

Durable Medical or Adaptive Equipment ordered? _____Yes _____No If Yes, please specify equipment and AE/DME supplier**:**

Dietary Orders or Recommendations? _____Yes _____No If Yes, please specify:

Modified Food Texture or Liquid Consistency? Circle all that apply:

Thin	Nectar	Honey	Pudding	Soft Chopped	Ground	Pureed	Normal food texture

Urinary Incontinence (N39.498)? _____Yes _____No

Bowel Incontinence (R15.9)? _____Yes _____No

Other Diagnostic, Screening and Preventive Services:

Referrals Ordered (ENT, Podiatry, RT, PT, OT, etc.):

How often are these evaluations needed?

Phys. Initial

PRN LIST OF MEDICATIONS (Make changes to accommodate patient's specific needs)

Constipation

Contact physician/nurse if no Bowel movement after 3 days or if no Bowel movement in 3 days that is accompanied by a distended abdomen and watery stool.

Colace 100mg: 1 tab by mouth 3 times a day if no bowel movement in 2 days.

Milk of Magnesia: 30ML by mouth at bedtime if no bowel movement in 3 days.

Cough with thin phlegm (mucus)/Sore Throat

Stop use and contact the physician/nurse if cough lasts more than 7 days or sore throat that lasts more than 3 days

Robitussin Maximum Strength Cough+Chest Congestion DM (Dextromethorphan HBr 20 mg, Guaifenesin 400 mg): 20ML orally every 4 hours for temporarily relief of cough due to minor throat and bronchial irritation as may occur with a cold with thin mucus.

Cough drops throat lozenge (Cēpacol, Chloraseptic, Halls, Ricola, Robitussin, Vicks): Dissolve 1 lozenge slowly in the mouth for temporarily relief of cough due to a cold, occasional minor irritation or sore throat. Repeat every hour as needed.

Dry Eyes

Do not use and contact physician/nurse if eye has discharge, pain or is accompanied by blurred or abnormal vision

Natural Balance Tears (PF) 0.1 %-0.3 %.: Wash hands first. Place the dropper directly over the eye and squeeze out 2 drops every 4 hours as needed to relieve dry, irritated eyes.

Minor Wounds/Cuts/Abrasions

Contact physician/nurse if swelling, redness, discharge, or pain is noted to the wound or abrasion

Neosporin: Cleanse the area with soap and water, then apply a thin film topically to minor wound/cut/abrasion twice daily as needed

Pain/Fever

Fever: Contact a doctor if oral temp is above 102 degrees Fahrenheit, lasts for more than 3 days, or gets worse.
Pain: Contact a doctor or nurse if pain is >5 on the pain scale, or non- verbal cues such as crying out, moaning, writhing or severe changes in behavior not known to be related to external or medication factors. Pain scale is 1-10, with 10 being the greatest. non-verbal cues for pain include (ie: face grimacing, tense body language, moaning, increase in sleeping).

Ibuprofen 200mg: 2 tabs by mouth every 6 hours if oral temp is between 99.6 degrees-102 degrees F or complaints of minor-moderate pain with a pain scale report < 5.

Acetaminophen 500mg: 2 tabs by mouth every 6 hours if oral temp is between 99.6 degrees-102 degrees F or complaints of minor-moderate pain with a pain scale report < 5. Do Not to exceed 4 grams (4000mg) in 24 hours

Allergy Symptoms

Stop use and contact a physician if needed or symptoms persist for more than 7 days in a row

Loratadine 10 mg: 1 tab orally once a day for temporary relief of symptoms associated with upper respiratory allergies (e.g., runny nose, itchy, watery eyes, sneezing, itching of the nose/throat).

Heartburn, Sour Stomach, Acid Indigestion, upset stomach associated with these symptoms

Contact a medical professional immediately should symptoms be accompanied by arm or jaw pain, Shortness of breath, sweating, paleness, dizziness, chest pain or other unusual symptoms.

Tums(Calcium Carbonate USP 500mg chew 2 tablets up to 3 times daily as symptoms above occur.

****Please add any other medications and / or directions specific to this individual below:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

****SEE THERAP CONSULTATION FORM FOR UTD, PATIENT SPECIFIC MEDICATION LIST****

I have reviewed all current medications, diagnosis, allergies, and diet. My signature and initials shall constitute permission to renew the medication ordered by me as needed for 1 year unless otherwise specified. New orders are written above:

Authorized Prescriber's Printed Name: _____ **Date:** _____

Prescriber's Signature & Title: _____

Provider may Fax this completed form to PPCH nurse case manager directly @ 303-424-6194.

The orders included within the pages of this physician's order, with the exception of controlled substances, are approved for 365 days unless otherwise indicated by signing physician. By providing a signature on any one page of this physicians order, physician acknowledges that all medications within the pages of this physicians order are to be refilled with orders good for 365 days.

Controlled substances must be prescribed separately, per DEA regulations, and must meet all criteria for a valid control prescription.

Meds marked w/ an asterisk "*" are orders by psychiatrist