Annual Physical

Information required by ODDD

Choices In Community Living, Inc.
1651 Needmore Road
Dayton, Oh 45414
937-898-2220

Name_____ Birthdate_____ Exam Date_____

TO BE COMPLETED BY THE PHYSICIAN

Height _____ Temp _____ Blood Pressure _____
Weight _____ Pulse _____ Respirations _____

	Normal? √ = yes	Comment		Normal? √ = yes	Comment
Eyes			Circulatory		
Ears			Skin		
Nose			Genitalia		
Throat			Rectum		
Mouth			Pelvic		
Head/Neck			Extremities		
Breast			Back		
Abdomen			Heart		

Testing Ordered:

Urinalysis _____ Pap _____
BMP _____ Mammo _____
CBC _____ Other _____

Diagnosis and Treatment: _____

_____

New Medications or **Medication Changes** prescribed this visit:

Written instructions are required by the ODDD

Medications	Instructions Specify Frequency, Dosage, and Duration	Diagnosis

Cannot prescribe "apply to affected area." Please state which area the medication is to be applied.

Cannot prescribe medication in a range (1-2 pills every 4-6 hours). Must be specific (2 pills every 6 hours).

Discontinued Medications: Please provide a date the med should be discontinued

Medication	Date
_____	_____
_____	_____
_____	_____

Physician's Signature:_____

This side to be completed by CICL Staff

Name _____

Current Medications: See attached. Please check one box.

☐ Current Physician's Orders ☐ Current Mars ☐ Brought Medication

*Physician's orders should be signed by the doctor every three months and turned into the pharmacy.

Allergies (Include Medications): _____

_____

Dietary Guidelines: _____

_____

Significant Medical History (Include hospitalizations, treatments, etc): _____

_____

_____

Current Medical Concerns(Behavioral changes, medications, questions, etc.): _____

_____

_____

Any Additional Information? _____

_____

CICL staff summary of visit - MUST COMPLETE:

_____

_____

_____

_____

_____

_____

☐ Is the doctor's office going to call or send a script to Tarrytown Pharmacy?

Fax (855) 617-7313 or Phone (855) 617-7312

☐ Is the doctor's office going to call or send script to another pharmacy?

Fax:_____ or Phone:_____

Physician's Name (Please Print) _____

Address _____

Phone Number _____

Next appointment is scheduled: _____

Staff's Name (Please Print)_____

Accompanying Staff's Name (Please Print)_____

PRN LIST

Name: _____ Date: _____

Check which over the counter medication this individual may use AS NEEDED: Please make changes as necessary.

*Pain or Temperature

_____ **Tylenol/Acetaminophen** take two 325mg tablets, by mouth, every 4 hours, as needed for general pain (excluding stomach pain), headache, or temperature over 100 degrees Fahrenheit. Not to exceed 12 tablets in 24 hours.

_____ **Other** (describe) _____

Quantity _____ Refills _____

*Laxative

Milk of Magnesia 30ml by mouth at bedtime, to produce a bowel movement after 3 days of no bowel movements. Not to exceed 60 ml in 24 hours. Call physician's office if medication does not produce a bowel movement.

_____ **Other** (describe) _____

Quantity _____ Refills _____

*Cough

_____ **Silitussin DM/Robitussin DM**, 10 ml by mouth every 4 hours as needed for a non-productive cough. Not to exceed 6 doses in 24 hours. If cough persists for 5 days, without a fever, call physician to make an appointment.

_____ **Other** (describe) _____

Quantity _____ Refills _____

*Creams / Ointments / Gels

_____ **Triple Antibiotic Cream/Ointment.** Apply to affected area topically three times daily for minor scratches/scrapes or broken skin. If not improved in 7 days, call physician for appointment.

_____ **Musculoskeletal Medication** of choice to relieve general pain and inflammation of muscles and joints. Follow directions on packaging unless otherwise stated by a physician.

_____ **Other** (describe) _____

Quantity _____ Refills _____

PRN LIST

*Diarrhea

_____ **Imodium AD** Take 4mg (two 2 mg tablets), by mouth, after first loose stool then, one 2mg tablet after each subsequent loose stool. Not to exceed 4 tablets in 24 hours. If loose stools continue despite medication, call physician for an appointment.

_____ **Other** (describe) _____

Quantity _____ Refills _____

*Other

_____ (describe) _____

_____

Quantity _____ Refills _____

Dietary Guidelines: _____

_____

_____

Work Limitations: _____

_____

_____

Physician's Printed Name: _____

Physician's Signature: _____

Date: _____

Tarrytown Expocare Legal Statement

All prescription orders are valid for 365 days unless otherwise indicated from the date signed. All medications may be dispensed each time during the order validation period on a monthly basis for up to a 31 day supply with 11 refills unless otherwise specified. PRN orders and conventional bulk items may be dispensed on an as needed basis during the order validation period for a one month supply. ***Controlled Substance Prescriptions should be written on a legal prescription pad, faxed directly to the pharmacy or verbally called into the pharmacy from the PHYSICIAN'S OFFICE or the hard copy should be sent in to the dispensing pharmacy***