**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<br>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)_____

Name:_____ Date:_____

Check which over the counter medication this individual may use as needed:

Please make changes as needed:

**Pain or Temperature**

_____ **Tylenol (Acetaminophen)** take two 325mg tablets, by mouth, every 4 hours, not to exceed 12 tablets in 24 hours, as needed, for general pain (not including stomach pains), headache, or temperature over 100 degrees Fahrenheit taken by an oral or temporal device

_____ **Other** (describe)_____

## Laxative

____ **Milk of Magnesia** 30ml by mouth at bedtime, as needed, not to exceed 60cc in 24 hours, give after three days of no bowel movements, to produce a bowel movement. Call RN if medicine does not produce a bowel movement.

_____**Other**_____

## Cough

_____**Robitussin DM**, 10ml, by mouth, every 4 hours, as needed, for non-productive cough, not to exceed 6 doses in 24 hours, if cough persists for 5 days, without a fever, call MD to make appointment.

_____**Other**_____

## Diarrhea

_____**Imodium AD** 2mg tablets, take 2 tablets (4mg), by mouth, after first loose stool then, one tablet (2mg) after each subsequent loose stool, as needed for loose stools, not to exceed 4 tablets in 24 hours. If loose stools continue despite medication, call MD for appointment.

## Other:

_____May use **Triple Antibiotic Cream/Ointment** apply to affected area(s) topically three times a day, as needed, for areas of broken skin, if not improved in 7 days call doctor for appointment

## Caffeine and Alcohol

_____Individual may consume beverages and/or items containing caffeine.

_____Individual may consume beverages containing alcohol.

_____Additional information:_____

____**Other**_____

**Dietary Guidelines**:_____

_____

**Work Limitations**:_____

_____

Physician's Signature:_____Date:_____

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 or for up to a 93 day supply with 3 refills when applicable.