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 / OVER THE COUNTER MEDICATIONS: STANDING ORDERS

Name_____ **Date** _____

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

***Pain or Temperature**

_____ Tylenol (acetaminophen), take two 325 mg tablets by mouth, every four 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)_____

***Laxative**

_____ MOM as a laxative, 30 ml 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)_____

***Antacid**

_____ Mylanta II as an antacid,10 cc every four hours by mouth, as needed for heartburn or upset stomach. Not to exceed 60 cc in 24 hours.

_____ Other (describe)_____

***Runny Nose**

_____ Sudafed (pseudoephedrine), take 1 tablet every 4 hours by mouth, as needed for a runny nose. Not to exceed more than 6 tablets in 24 hours.

_____ Other (describe)_____

***Cough**

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

_____ Other (describe)_____

***Creams/Ointments/Gels**

_____ Triple Antibiotic Cream/Ointment. Clean and dry the affected skin area. If you are using ointment, Wash your hands first. Then apply a small amount of medication (no more than can fit on your finger tip) in a thin layer topically on the skin and rub gently. Can apply every 8 hours as needed for minor scratches/scrapes or broken skin. Do not exceed 3 doses within 24 hours. If it does not improve in 7 days, call Phyician.

_____ Musculoskeletal medication (Bengay, Icyhot, Biofreeze, Voltaren, etc) Apply a thin layer topically of medication to the affected area to relieve general pain and inflammation of muscles and joints 4 times a day (every 6 hours) as needed. Do not exceed 4 doses within 24 hours. After applying medication, wash your hands unless you are using this medication to treat the hands. If treating the hands, wait at least 30 minutes after applying the medication to wash your hands.

***Diarrhea**

_____ Imodium AD, take 4 mg (2 two mg tablets) by mouth for diarrhea, after first loose stool then, 1 two mg tablet after each subsequent loose stool. Not to exceed 4 tablets in 24 hours for diarrhea. If loose Stool continues despite medication, call the physician for an appointment.

_____ Other (describe)_____

***Other**

_____ Other (describe)_____

***Unless specified, if symptoms persist for 48 hours, contact the physician.**

Dietary Guidelines:

_____

_____

_____

Work Limitations: _____

_____

_____

Over the counter items to be purchased locally:

_____Mouthwash

Pour 20 milliliters (4 teaspoons) of mouthwash into a cup for bad breath, plaque, or gingivitis. Empty the cup into your mouth. Don't dilute the solution with water. Swish for a full 30 seconds. While rinsing swish in your mouth. Do not swallow solution. Spit the solution out in the sink. If swallowed, get medical help or contact the Poison Control Center right away.

_____Denture Cream (Fixodent, Polident, Poligrip)

Apply adhesive in short strips, not too close to the partial edges. Avoid applying too much, or oozing may occur. Rinse mouth before inserting dentures. Press denture into place, hold firmly and bite down for a few seconds to secure hold.

_____Anti-itch cream (Cortaid or Lanacane)

For adults and children 2 years of age and older: Apply to affected area of the skin for itching no more than four times daily (every 6 hours) as needed. Do not exceed 4 doses within 24 hours. Wash and dry your hands before using. Clean and dry the affected area. Shake the lotion or foam well just before using. Check the product package to see if the spray needs to be shaken before each use. Gently dry the area before application.

_____Insect Repellant (OFF)

Shake the container and spray evenly onto exposed skin and/or clothing to prevent bug bites as needed four to eight inches away, or as directed on the label. Do not apply near eyes and mouth, and apply sparingly around ears. When using sprays, do not spray directly into face; spray on hands first and then apply to face. Never use repellents over cuts, wounds, or irritated skin. If swallowed, rinse out mouth, drink water, and contact poison control.

_____Lip Balm (Chapstick, Blistex)
Apply a thin even layer of balm to both upper and lower lips as needed for dry, cracked lips. Reapply as needed throughout the day. If swallowed, rinse out mouth, drink water, and contact poison control.

_____Barrier Products (Aquaphor, Desitin)
Apply evenly to the desired area for dry, cracked, or irritated skin/rash: apply the barrier cream to the skin in a thin layer to the desired area of the skin as needed. Use gentle, circular motion to spread evenly. Contact a doctor if rash is no better in three days.

_____Cough Drops (Halls, Vapo Cool, Ricola)
Dissolve one drop slowly in the mouth every two hours as needed for cough. If cough persists for more than a week, or is accompanied by other symptoms, contact doctor.

_____ Sunscreen
Minimum SPF 50 use enough sunscreen to cover all areas of exposed skin to prevent sunburn. Apply sunscreen at least 15 minutes before going outside. Reapply every 2 hours and more often after swimming or sweating. Make sure to check the label on the bottle as each sunscreen may be different.

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 hand copy should be sent in to the dispensing pharmacy

Bedtime Medication Authorization Form

Name_____ Date_____

Date of Birth_____

Home_____

Print Doctor/Nurse Practitioner's Name_____

Physician/Nurse Practitioner's Phone Number_____

Bedtime Medications for the Client_____

_____

_____

_____

_____

I give permission for this client to receive their bedtime medications between the hours of 8:00pm and 11:59pm.

_____

Physician/ NP Signature

Please fax this signed form back to _____ at _____.

If you have any questions, please contact the Program Manager_____

at _____.

*Send a copy of this form to the pharmacy. If bedtime meds change, a new form needs to be signed and sent to the pharmacy. This form needs updated annually.