Physician's Orders and Medical Records Authorization

The CarePartners Dementia Day Center is required to keep Physician's Orders and Medical Records Authorization on file for medication administration and for emergencies. Following this page, you will find the Physician's Order form which we ask that you either bring to the member's physician's office or fax to them. They can fax the form back to us once complete. Additionally, we have included a letter to the member's physician with a request for authorization for the member's medical records. You can return this letter and authorization form to the Day Center at the Enrollment appointment. The potential member cannot attend the Day Center until the Physician's Orders Form is complete.

Attached:

1. Letter to Physician
2. Authorization Form for Medical Records
3. Physician's Orders Form

Date: _____

RE: Release of Medical Records

Dear Dr. _____,

Your patient, _____, DOB _____, has applied for enrollment at CarePartners Dementia Day Center and day care facility specializing in the care of individuals with Alzheimer's disease and other forms of Dementia.

In order to ensure that your patient is appropriate for the Day Center, the Physician's Orders form must be received before he/she will be permitted to attend.

To complete our Medical Records, a brief medical history and the completed Physician's Order Form should be provided to the Day Center as soon as possible.

You may mail or fax this information to:

CarePartners Dementia Day Center
3838 Aberdeen Way
Houston, TX. 77025
Or remit a fax to:
(877) 795-2696
Thank you kindly for your assistance.

Sincerely,

Carol Stewart, RN
Day Center Nurse

Attachments: Physician's Orders Form, Authorization for Release for Medical Records

Authorization for Release of Medical Records

RE: _____
(Patient's Name)

DOB: _____
(Patient's Date of Birth)

I hereby authorize and request that _____ release medical
(Physician)
information as needed concerning the above named patient's medical history, current health status, medication regimen and treatment plan to:

Day Center Nurse: Carol Stewart, RN

CarePartners Dementia Day Center
3838 Aberdeen Way
Houston, TX 77025
713-682-5995 (Phone)
877-795-2696 (Fax)
daycenter@carepartnerstexas.org

_____ _____
Signature of Caregiver/Responsible Party Date

Physician's Evaluation and Order Form

Every line item on this form needs a response written in or circled

Patient's Name: _____ DOB: _____

I last examined the patient on _____ (Patient must have been examined by physician within the last 12 mos)

BP_____ Pulse_____ Respiration_____ Height_____ Weight_____

Diet: _____ Allergies: _____

Mobility *(circle one)*: Self-Ambulatory Cane Walker Wheelchair

Is client able to bear weight on his or her legs *(circle one)*? Yes No

Diagnosis of Dementia *(circle one)*: Yes No

Other Diagnoses: _____

_____

Does the patient have a disease that is listed under the Texas Notifiable Conditions Chart? Yes No

If yes, what is the disease: _____

Past Medical History *(Hospitalizations, surgical procedures)*_____

_____

_____

TB Test or Chest X-ray Results: Date of Last Test: _____

Current Medications *(Drug, Dose, Route, Frequency - Medications given at center will appear on MAR)*

_____ _____ ____See attached MD printed medication list

_____ _____

_____ _____

Specific Orders *(circle yes or no for each)*:

Patient is medically stable and able to participate in programs offered at CarePartners. Yes No

Patient may participate in supervised outings and activities as tolerated. Yes No

Patient may have contact with animals. Yes No

Patient may participate in chair level or mild exercise. Yes No

Nurse may crush medications or open capsules. Yes No

Acetaminophen 500mg as directed on bottle PRN pain/fever Yes No

Ibuprofen 200mg as directed on bottle PRN pain/fever Yes No

Physician/NP's Signature: _____ License #_____ Date:_____

Printed Name: _____ Phone #_____ Fax# _____

CarePartners Dementia Day Center Nurse Signature: _____ Date: _____