CarePartners

Provider’s Orders and Medical Records Authorization

CarePartners’ Dementia Day Center is required to keep a Provider's Evaluation with specific orders and a Medical Records Authorization on file for medication administration and emergencies. Following this page, you will find the required forms to be completed by the member’s medical provider. The forms must be faxed or returned in-person prior to the scheduled enrollment appointment.

Attached:

1. Letter to Provider
2. Authorization Form for Medical Records
3. Provider's Evaluation and Orders

CarePartners

Authorization for Release of Medical Records

RE: _____
(Patient's Name)

DOB: _____
(Patient's Date of Birth)

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

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

Responsible Party (Please Print): _____

Responsible Party Signature: _____

Contact: #_____ Date _____

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Date: _____

RE: Release of Medical Records

Dear Dr./NP, _____,

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

To ensure that your patient is eligible to attend the Day Center, the attached forms must be received prior to the patient's admission to our facility.

Please provide a brief medical history along with the completed Provider's Order form.

You may fax this information to:

CarePartners' Dementia Day Center
3838 Aberdeen Way
Houston, T.X. 77025
Fax: (877) 795-2696

Sincerely,

Attachments: Provider's Orders Form and Authorization for Release for Medical Records

Provider's Evaluation and Specific Orders Form

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: _____