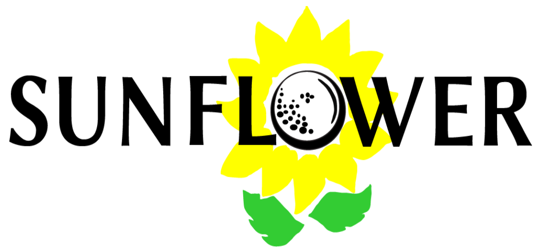


SUNFLOWER MEDICAL ADULT DAYCARE

300 BROADWAY, BAYONNE, NEW JERSEY 07002

PHONE: (201) 243 - 0555 | FAX: (201) 243-1836|
nursing@sunfloweramdc.com

Client Name:_________________________ DOB: ___________ Today's Date: _______________________

ALLERGIES:____

HISTORY

Primary / Present Diagnosis :____

Recent / Prior Surgeries:____

Past Medical History: ____

MENTAL STATUS: ( ) Alert & oriented x3 ( ) Forgetful ( ) Confused ( ) Disoriented ( ) Aphasic

Additional Comments____

VITAL SIGNS: BP______, Pulse/HR______, Height______, Weight ______ Weight Changes ( )Yes ( ) No

IMMUNIZATIONS: (please insert dates)

Last Pneumovax: __________ Last Influenza __________ Last PPD __________

Covid Vaccine type:________ 1st Vaccine Date__________ 2nd Vaccine date __________

Covid Booster dates: 1st Booster ____________ 2nd Booster ___________ N/A ( )

Additional comments ____

PHYSICAL FINDINGS:

General Physical Condition: ( ) Good ( ) Fair ( ) Poor Comments: ___________________________________

Bowel & Bladder: ( ) Continent ( ) Partially Incontinent ( ) Incontinent ( ) Use of Incontinent Product(s)

PLEASE CIRCLE ONE:

Eyes	WNL	Glasses	Cataracts	Glaucoma
Mouth	Natural teeth	Dentures upper/lower	Partial upper / lower	Dentures Upper / lower
ENT	WNL	Deficit with hearing	Hearing aides	

LUNGS: ____

HEART: ____

ABDOMEN: ____

BACK/SPINE: ____

EXTREMITIES: ____

LAB WORK: Please fax most recent lab work, x-rays or studies.

Is client permitted to take his/her own medication while at the day program:( ) yes ( ) No ( ) other ______

If client needs assistance with taking medication while at the day program an MD script is required. Please attach.

Name and **phone number** of clients current pharmacy _______________________

MEDICATIONS: please attach separately or list below

Medication Name	Dosage / Frequency	DX

DIET ORDER: ( ) HOUSE ORDER ( ) DIABETIC: NCS ( ) RENAL ( ) OTHER DIET______________________

DIET CONSISTENCIES:( ) CHOPPED ( ) REGULAR ( )PUREED( ) FLUID RESTRICTIONS: _______CC PER DAY

FEEDING ABILITY: ( ) INDEPENDENT ( ) ASSIST W/ MEALS ( ) SUPERVISION W/MEALS

AMBULATION:( ) INDEPENDENT ( ) INDEPENDENT W/ASSISTIVE DEVICE ( ) NON-AMBULATORY / WHEELCHAIR BOUND ( ) ASSISTANCE WITH TRANSFERS ( ) COMMENTS: ____________________________

ASSISTIVE DEVICES: CANE ( ) WALKER ( ) ROLLING WALKER ( ) WHEELCHAIR ( ) OTHER: ___________

TOILETING: ( ) INDEPENDANT ( ) MINIMAL ASSIST ( ) COMPLETE ASSIST COMMENTS: ______________

VITAL SIGNS:

BP: ( ) Daily ( ) _____x Per Week ( ) Monthly ( ) Comments: ____

Parameters: Call MD Syst. BP > 180 < 90 and Diast. >90 < 60. Resting heart rate: >100 < 50, Resp >20 < 12

(Notify MD x 2 days asymptomatic or x1 day symptomatic)

BLOOD GLUCOSE MONITORING: Daily: ( ) Yes ( ) No Weekly: ( ) Yes ___ X times per week ( ) No

Monthly: ( ) Yes ( ) No ( ) N/A

If applicable and no sliding scale Notify MD for BS: (> 250 x 2days) (< 60 x 2 days)

ADDITIONAL RECOMMENDATIONS / CONSULTS: If client requires any additional services such as labs ordered or therapy that is offered at the day care center e.t.c PLEASE fax a script!

I confirm that this patient has medical needs and would benefit from participation at: Sunflower AMDC ( ) Yes ( ) No

** A physician stamp is allowed if available

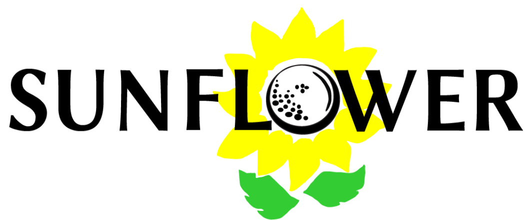
Physicians Name / Practice please print: ______________________________

Address: ____

Phone: ____ Fax:________________________________

Physician Signature: _____________________________ Date:________________________________

Nurse Signature / Date Received:____



SUNFLOWER MEDICAL ADULT DAY CARE

300 BROADWAY, BAYONNE, NEW JERSEY 07002

PHONE: (201) 243 - 0555 | FAX: (201) 243-0888

nursing@sunfloweramdc.com

Name:_______________________________ D.O.B:_____________
Physician Name: ____
Physicians signature:_______________________________________

PLEASE fill in B/P & BS STANDING ORDERS for HTN and DM clients

- BP: Once per week: Yes ( ) No ( ) _____x Per Week ( ) Monthly ( ) Comments:

____

Parameters: Call MD Syst. BP > 180 < 90 and Diast. >90 < 60. Resting heart rate: >100 < 50, Resp >20 < 12

(Notify MD x 2 days asymptomatic or x1 day symptomatic)

- BLOOD GLUCOSE MONITORING: Once Weekly: Yes ( ) No ( ) ___ X times per week

Monthly: ( ) Yes ( ) No ( ) N/A

If applicable and no sliding scale Notify MD for BS: (> 250 x 2days) (< 60 x 2 days)

Chest pain	Administer nitroglycerine 0.4mg S.L 5 mins apart x3 doses, apply O2 @ 2L/M, monitor vital signs, call 911, MD and family, send to ER, ambulance
Shortness of Breath	In emergency situations, stop activity, have clients sit, apply O2 @ 2L/M, via nasal cannula, assess resp. status and VS, call 911, MD and family, send to ER, ambulance
Hypoglycemic reaction (conscious)	Glucose Gel-PO 15g, call 911, call MD and family
Hypoglycemic reaction (unconscious)	Glucagon Pen as directed, call 911, call MD and family
Fever	Tylenol 650 mgPO Q4H, for temp >99.6 or as directed by MD, Notify MD for temp >101.0. Encourage fluids
Headache, Pain or Discomfort	Monitor VS, tylenol 650mg PO Q 4 Hrs for 3 dose, notify MD for abnormal VS
Diarrhea	Clear liquid diet, Kaopectate 2 tsp. or Pepto Bismol 2 Tbsp PO with each loose BM x3 doses. Encourage fluids, notify family and if ineffective call MD

Constipation	MOM 30 cc PO QD PRN, if needed more than once, obtain an MD order, enc. fluids
Digestive tract	Maalox 1 tsp. PO Q 30 mins x3-4 doses, continue to monitor complaints or give Pepto Bismol 2 Tbsp Q 1H x2 doses, Notify family and MD if upset stomach unrelieved. Continue to monitor complaints
Skin irritation/Excoriations	Rash: Cortaid oint. 0.5% to affect area, notify family if problem continues. Cont. to monitor refer to MD. Dry skin, apply lotion as per nsg discretion. Barrier cream (Zinc oxide) to excoriations.
Sore throat	Cepacol Lozenges 1 tab PO Q2H,PRN x5 doses, enc to gargle with salt water and follow up with MD if persists
Bee sting	For allergic reaction, use Epipen STAT, apply ice to area, notify MD STAT,l cont. to monitor airway and VS, send to ER
Cuts/Abrasions	Assess wound, cleanse with warm soapy water and rinse, apply Bacitracin and dry cover with sterile dressing or bandaid
Burns	1st degree(redness) apply cool water:Sunburn-assess and apply solarcaine for pain as directed. More serious use cold water and send to ER
Eye Irritation	Irrigate using eye wash, observe and follow up with MD