Applicant's Name: _____DOB: _____

Applicant Medical Information

The individual listed below desires to enroll in a CORA's Intergenerational Center Adult Day Health Program. Supervision is provided during the day for disabled and elderly adults in a protective setting approved by the NC Department of Health Human Services, Division of Aging and Adult Services to provide for personal care; to promote social, physical and emotional well-being; and to offer opportunities for companionship, self-education and other leisure time activities.

In order to protect both the applicant and other participants, it is necessary that we have medical information on each person. This information will also assist the CORA's IGC personnel in working with this person.

NOTE: Medical Information Form must be completed within prior three months of enrollment and updated annually.

Patient's Name: _____ **DOB**: _____

Most Recent Date Seen by a Doctor: _____

Primary Diagnosis: _____ **Secondary Diagnosis**: _____

Date of TB Test: _____TB Test Results: ☐Positive ☐Negative

COVID Test most recent: _____ Results: ☐ Positive ☐ Negative

COVID vaccination: ☐ Yes ☐ No Verified: _____

Current Blood Pressure: _____ Pulse/Respiration: _____/_____

Normal Participant Range: Blood Pressure: _____ Pulse/Respiration: _____

Weight: _____ Height: _____

Normal Participant Blood Sugar range: _____

Normal Participant Heart Rate: _____

Are there any special precautions or limitations in functioning regarding care with which we should be familiar? Yes ☐ No☐

Please Specify: _____

Applicant's Name: _____DOB: _____

Diagnosis/Physical Health Status:	**Yes**	**No**	**If Yes, Please Comment**
Arthritis, Rheumatism	Yes ☐	No ☐	
Asthma	Yes ☐	No ☐	
Emphysema, Chronic Bronchitis	Yes ☐	No ☐	
Tuberculosis	Yes ☐	No ☐	
High Blood Pressure	Yes ☐	No ☐	
Heart Condition	Yes ☐	No ☐	
HIV	Yes ☐	No ☐	
Circulation Problems	Yes ☐	No ☐	
Stomach Ulcers	Yes ☐	No ☐	
Diabetes	Yes ☐	No ☐	
Gastro-Intestinal Problems	Yes ☐	No ☐	
Urinary Tract Problems	Yes ☐	No ☐	
Incontinence Bowel	Yes ☐	No ☐	
Incontinence Bladder	Yes ☐	No ☐	
Anemia	Yes ☐	No ☐	
Effects of Stroke	Yes ☐	No ☐	
Epilepsy	Yes ☐	No ☐	
Glandular Disorders	Yes ☐	No ☐	
Allergies, Allergic Reactions	Yes ☐	No ☐	
Skin Disorders	Yes ☐	No ☐	
Communicable Diseases	Yes ☐	No ☐	
Hearing Impairment	Yes ☐	No ☐	
Vision Impairment	Yes ☐	No ☐	
Alzheimer's disease	Yes ☐	No ☐	
Dementia	Yes ☐	No ☐	
Parkinson's	Yes ☐	No ☐	
Developmental Disabilities/Delay	Yes ☐	No ☐	
Cerebrovascular Disease (Stroke)	Yes ☐	No ☐	
Other	Yes ☐	No ☐	

Additional Comments:

_____

_____

_____

_____

_____

Applicant's Name: _____DOB: _____

Mental/Behavioral Health Status:	**Yes**	**No**
Organic Brain Damage	☐	☐
Arteriosclerosis	☐	☐
Personality Disorders	☐	☐
Loss of Appetite	☐	☐
Insomnia	☐	☐
Feeling of Worthlessness	☐	☐
Loss of Interest	☐	☐
Hypochondria	☐	☐
Suspiciousness	☐	☐
Hallucinations	☐	☐
Delusions	☐	☐
Distortion in thinking	☐	☐
Confusion	☐	☐
Impaired Judgement	☐	☐
Memory Loss	☐	☐
Hazardous Behaviors	☐	☐
Alcohol Abuser	☐	☐
Drug Abuser	☐	☐
Wander	☐	☐
Aggression	☐	☐
Outburst/crying/yelling	☐	☐

Additional comments:

_____

_____

_____

Applicant's Name: _____DOB: _____

Current Medication(s):

Medication	Route	Dosage	Frequency

Allergies (Food/medication/environmental)	Reactions

Applicant's Name: _____DOB: _____

Additional information or details that would be beneficial to the Admission Review Committee in evaluating the appropriateness of participant/applicant to participate in CORA's Intergenerational Center Adult Day Health.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical provider completing form:

Print Name: _____

Signature: _____ Date: _____

Phone number: _____

Fax number: _____

Address: _____

Caregiver acknowledges review of the information on this form.

Print Name: _____ Signature: _____ Date: _____

Applicant's Name: _____DOB: _____

Standing Orders

PLEASE BE SPECIFIC

*The following orders once signed by licensed medical provider (MD, DO, NP, PA) are effective for one (1) year and **must be updated at least yearly.***

☐Yes ☐ No Acetaminophen 350 mag 1-2 tablets every 4 hours as needed for pain or fever

☐ Yes ☐ No Maalox or generic version 30 cc every 4 hours as needed for stomach upset

☐Yes ☐ No Over the counter cough drop every 2 hours as needed for cough

☐ Yes ☐ No Tums or generic version 1-2 tablets every 4 hours as needed for indigestion/heartburn

☐ Yes ☐ No Imodium or generic version per manufacturer's instructions as needed for diarrhea

☐Yes ☐No Milk of Magnesium or generic version 30 cc every day as needed for upset stomach

☐Yes ☐No Normal saline drops per manufacture's instructions as needed for dry/irritated eyes

☐Yes ☐No Minor wound care as needed cleanse with peroxide, apply triple antibiotic and if needed dressing/bandage

☐Yes ☐No May check blood sugar with finger stick testing unit as needed for signs/symptoms of hyper/hypo-glycemia

☐Yes ☐No Liquid Bandage can be applied to open areas as needed

☐Yes ☐No 81 mg of aspirin in the event of heart attack or stroke

Licensed Provider Signature: _____ Date: _____

Responsible Party/Caregiver: _____ Date: _____