Medical Evaluation for HO'ONANI DAY CENTER

To Be Completed By Physician

(phone) 896-6417 / (fax) 808-443-0521
Ho'oNani Day Center / 65-1267B Lindsey Road, Kamuela, HI 96743

Patient Name Last First Middle

Physician's Name Physician's Phone Number

A 2 STEP TB TEST IS REQUIRED FOR NEW CLIENTS
IS YOUR PATIENT FREE FROM COMMUNICABLE DISEASE?
(PLEASE CIRCLE) YES/NO

DATE OF FIRST TB TEST OR CHEST X-RAY _____ **RESULT**_____

DATE OF SECOND TB SKIN TEST _____ **RESULT** _____

IF THE QUANTIFERON-TB GOLD TEST WAS PERFORMED, PLEASE INCLUDE NEGATIVE TEST RESULTS IN LIEU OF THE ABOVE INFORMATION.

IF A CHEST X-RAY WAS PERFORMED IN LIEU OF TB SKIN TEST, PLEASE ATTACH X-RAY RESULTS & A COPY OF THE POSTIVE TB SKIN TEST WHICH LED TO THE X-RAY

Medical Information

PRIMARY DIAGNOSIS _____

SECONDARY DIAGNOSIS _____

PHYSICAL DISABILITIES _____
_____
_____

MENTAL FUNCTIONING: CURRENT LEVEL-MENTAL CAPACITY, ORIENTATION BEHAVIOR PROBLEMS, ETC. . . _____
_____
_____

PLEASE INITIAL IF PATIENT MAY HAVE: TYLENOL _____ ANTACID _____
SPECIAL DIET? _____ ALLERGIES: _____

PLEASE ATTACH MEDICATION SHEET OR WRITE A LIST OF PRESCRIBED MEDICATIONS ON BACK OF THIS DOCUMENT.

(Full Code) CPR _____ or (No Code) DNR_____

PLEASE COMPLETE A POLST

WAIVER FOR MEDICATION DISTRIBUTION

As the physician representing the above named applicant for Ho'oNani Place, I authorize the certified staff of Ho'oNani Day Center to assist with my patient's prescribed medication. (Please Initial) Yes _____ No _____

_____ _____
Physician's Signature Date