SHARE YOUR CARE
ADULT DAY SERVICES

OPERATIONS MANUAL

CC-9050Q PHYSICIAN'S FORM

Revised 02/26/2021

PERSON SERVED:	SOCIAL SECURITY #:	DATE OF BIRTH:

I hereby give my permission for this physician to provide the following information to Share Your Care, Inc.

______________________________ Patient's Signature

______________________________ Authorized Legal Representative's Signature

Physician:	Address:	Phone Number:

Dear Physician: We would appreciate your assistance in evaluating the health and functional status of your patient. This information is important for the purpose of designing therapeutic day services appropriate to this person's abilities and situation. Please feel free to include any assessments or other information which you deem pertinent. If you are aware of other physicians who treat this patient, please indicate this in the space provided. Thank you for your time.

Is there another physician who treats this patient? ___Yes ___No	Name & Telephone # of other physicians:

Health Information:

TB Test or Chest X-Ray Within One Year Evidencing Free of Active TB:-Yes -No	Does the Patient have active: _Hepatitis A _Hepatitis B _Hepatitis C Does the Patient have other communicable/contagious/notifiable diseases: Yes -No If Yes, specify:	
Primary Diagnosis:	Secondary Diagnosis:	Behavioral Health Diagnosis:
Vaccines (Date): Tetanus ______ Influenza ______ Pneumonococal ______ Other ______		Date Last Seen By Physician: __________

Rx and Food Allergies:

Dietary Instructions for Day Program (Check All That Apply): Regular ____ No Concentrated Sweets ____ No Added Salt____
Foods to Avoid: ________________________

Ponderosa Location Only: **{Modified ____ (*Please Check All That Apply for Modified*) Soft____ Chopped (*Specify Size, ex; Quarter, dime, etc.*)____________ Ground (1/4 inch Pieces)____ Minced (1/8 inch Pieces) ____ Pureed____ }**

Other Dietary Considerations:

Orientation: Patient is oriented to: Person __ Place __ Time __ Date __ Circumstances __

Presenting Problem(s): Organic Disorder (as Dementia): MMSE Score Personality Change Short-term Memory Deficit

Schizophrenia __ Depression Disorder __ Anxiety Disorder __ Other ______________________________

Medications:

Psychotropic Name:	Dosage:	Frequency:	Target Symptoms:
Other Medications Name:	**Dosage:**	**Frequency:**	**Target Symptoms:**

Is this patient able to self-medicate? Yes __ With Assistance __ No Comments:

If patient receives psychotropic meds., the physician certifies the patient and/or caregiver has been educated regarding contraindications, side or unusual effects, Psychotropic meds. are only used as an adjunct to Mental Health Services. Patient or their legal representative was involved with all medication/health care decisions. Physician's Initials _______

This patient is at risk for: __ Abuse or Exploitation __ Neglect (including self-neglect) __ Pre-Mature Institutionalization
I recommend Adult Day Care Services: __YES __NO

Physician's Signature:	Date:

SHARE YOUR CARE, INC.
BOX 35101
ALBUQUERQUE, NM 87176

PROGRAM SITE: ______________________________
SITE PHONE #: ______________________________
SITE Fax #: ______________________________