509 Amherst St.
Winchester, VA 22601
kdevolites@adultcarecenter.net
www.adultcarecenter.net

Adult Care Center
of the NSV, Inc.
Encouraging, engaging, & enriching since 1993

Office Phone
(540) 722-2273
Fax Phone
(540) 450-2263

Dear Physician,

Please ensure that this form is fully completed, with each section containing a response — including **N/A** where applicable. We also require a **current, signed, and dated medication list** for the patient.

If the patient has a **Durable Do Not Resuscitate (DNR) order**, please sign accordingly so the family can provide us with the **original document**.

Your thorough and timely completion of these items enables us to deliver accurate and efficient support to the family. We appreciate your attention to detail and your partnership in care.

ADULT CARE CENTER OF THE NORTHERN SHENANDOAH VALLEY, INC.

HONORARY BOARD MEMBERS
Charles Harris, Diane & Chris Shipe, JJ Smith
BOARD OF DIRECTORS
Linda Shimer, MA CCC-SLP, President; Dr. Rebecca Morrison, Psychologist, Vice-President; Christopher Francis, MSN, Treasurer; Rosalie Lewis, MSN, MS, RN, FCN, Secretary; Ann B. Colson, RN, CCRN, BSN; Katie Harvard; Janet Murphy; Tess Newcome, MS Applied Behavioral Analysis , Jeannie Shiley, NHA, CASP; Varina (Vee) Tavenner;
Dr. Mariecken Fowler, Neurologist – Consultant to the Adult Care Center

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REPORT OF PARTICIPANT PHYSICAL EXAMINATION

Examination is to be completed by or under the direction of a licensed physician within 30 days prior admission. Report is to be kept as part of the participant's permanent record. ***ALL FIELDS MUST BE FILLED OUT BY HEALTH CARE PROVIDER.***

_____

NAME DATE OF BIRTH DATE OF PHYSICAL EXAMINATION

_____

ADDRESS

_____

TELEPHONE

Diagnoses and significant problems:

_____

_____

_____

General physical condition, including a systems review as medically indicated:

_____

Height: Weight: Blood pressure: _____

Diet: Please Be Specific & Check

- ○ Regular
- ○ No Added Sugar
- ○ No Added Salt

Food intolerances:

- ○ No Nuts
- ○ No Seeds
- ○ Other Intolerances

_____

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Dr. Mariecken Fowler, Neurologist – Consultant to the Adult Care Center

Allergies – (food, medicine, animal or other), and ***reaction***:

_____

_____

_____

_____

Therapy, treatments or procedures participant is undergoing or should receive, and by whom:

_____

_____

_____

Restrictions or limitations on activities or program participation:

_____

_____

_____

Medications (Including dosages, route, and frequency of administration):

_____

_____

_____

Is this person:

Capable of administering his own medications without assistance? _____yes _____no

Not capable of administering his own medications without assistance? _____yes _____no

Is this person ambulatory? _____yes _____no

Is this person:

Physically and mentally capable of self-preservation by being able to respond to an emergency, either to an area of safe refuge area or from the building, without the assistance of another person, even if he may require the assistance of a wheelchair, walker, cane prosthetic device, or a single verbal command.

_____yes _____no

By reason of physical or mental impairment is not capable of self-preservation without the assistance of another person.

_____yes _____no

Is this person capable of understanding his/her rights? _____yes _____no

Acetaminophen Administration:

Permission is given to administer acetaminophen: _____yes _____no

If yes, please answer the following five sections:

Symptoms that indicate use of this medication:

_____

_____

Medication dosage (note: must be exactly specified; for example, 'two 325 mg tabs' instead of 1-2 tabs)

_____

Times the medication is to be given in a 24-hour period (note: must be exactly specified; for example, 'q 4 hours prn' instead of q 4-6 hours prn')_____

****Directions if symptoms persist***:

_____

_____

Any additional instructions:_____

Signature:_____ Date:_____

_____

(Please print or type physician's name here)

Address (Street, City, State, Zip Code)

_____

Telephone:_____ Fax: _____

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

_____	_____	_____
Physician's Printed Name	Physician's Signature	Emergency Phone Number

_____	_____
Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf

Copy 1 – To be kept by patient

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

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_____	_____	_____
Physician's Printed Name	Physician's Signature	Emergency Phone Number

_____	_____
Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf

Copy 2 – To be kept in patient's permanent medical record

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

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_____	_____	_____
Physician's Printed Name	Physician's Signature	Emergency Phone Number
_____	_____	
Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf	

Copy 3 – Used to order DDNR jewelry EMS – 7105 6/2011