



Eliza Huntington MEMORIAL HOME

Administrator: Tina M Yeitz
Director of Resident Care: Sandra Hill
Business Manager: Amanda Papineau

At this time we feel it is necessary to have permission on whether or not your patient may have the following over the counter medications. Please indicate below as you see appropriate for the following individual.

Regular strength Tylenol 325mg – Adults take 2 tablets every 4-6 hours as needed. Do not take more than 10 tablets in 24 hours

Yes _____ No _____

Extra Strength Tylenol 500mg – Adults take 2 tablets every 6 hours while symptoms last. Do not exceed 6 tablets in a 24 hour period

Yes _____ No _____

Tylenol PM – Adults take 2 tablets at bedtime. Do not take more than 2 in a 24 hour period.

Yes _____ No _____

In 24 hours

Yes _____ No _____

Ibuprofen 200mg – Adults take 1 every 4 to 6 hours while symptoms persist, if pain or fever does not respond 1 to 2 tablets may be used. Do not take more than 6 in a 24 hour period.

Yes _____ No _____

Imodium – Adults take 2 tablets after the first loose stool and 1 after each subsequent loose stool. Do not take more than 4 tablets in a 24 hour period.

Yes _____ No _____

TUMS - Adults chew 2-4 tablets as symptoms occur or as directed by your doctor. Do not chew more than 10 tablets

Yes _____ No _____



Eliza Huntington MEMORIAL HOME

Milk of Magnesia – Adults 2-4 tablespoons (30-60ml) for constipation once a day, preferably at bedtime followed by 8oz of fluid. May be divided in doses.

Yes _____ No _____

Pepto Bismol – Adults take 2 tablespoons every ½ to 1 hour as needed, Do not take more than 8 doses (16 tablespoons) in 24 hours.

Yes _____ No _____

Tussin Cough Medicine - Adults take 2 teaspoons every 4 hours for cough, Do not take more than 6 doses in a 24 hour period

Yes _____ No _____

Patient may have alcoholic beverage –

Yes _____ No _____

******* (Orders are good until physician determines a need for change)**

Physicians signature: _____ Date: _____



Eliza Huntington MEMORIAL HOME

Physician Evaluation and History

Your patient, _____ has applied for admission to the Home. Please complete this form for our records so that we may determine the level of care she may need.

Date last seen: _____

Age: _____ Height: _____ Blood Pressure: _____ Pulse: _____ Tuberculosis Test: _____

General Appearance: _____
 Current Diagnosis: _____
 Chief Complaints: _____
 Past Health History
 Adult Illnesses: _____ Family History: _____
 Surgeries: _____ Allergies: _____
 Injuries: _____

Mental Condition Clear Partly Confused Very Confused

Are there any psychiatric problems? Yes No

If yes, please explain: _____

Recent Infections? Yes No Please explain: _____

Treatments Received: _____

Skin: _____ Chest: _____ Head and Neck: _____

Heart: _____ Lungs: _____ Gastrointestinal: _____

Genitourinary: _____ Gynecological: _____

Continent: _____ Incontinent: _____

Musculoskeletal: _____ Neurological: _____

Ambulation: Excellent Good Fair Poor
 Cane Walker Needs Wheelchair

Does the patient need any of the following? PT OT Therapies



Eliza Huntington MEMORIAL HOME

Insulin Dependent: _____ Is Oxygen needed: _____ Any appliances: _____

Special diets needs: _____ Assistance with ADL's: _____

Are there any other medical concerns?

Please list current medications:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

It is the policy of the Home to supervise all resident medications.

I, _____ M.D., certify that this patient does not require nursing care and is ambulatory under the meaning of the Connecticut State Law. (The term ambulatory under the meaning of the law when used in relation to a person, shall mean one who, without the aid of another, is physically and mentally capable of walking a normal path to safety, including the ascent and descent of stairs.)

Signature: _____ Date: _____