Eliza Huntington MEMORIAL HOME

Administrator: Tina M Yeitz
Director of Resident Care: Sandra Hill
Business Manager: Christine Longo

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.

Patient Name: _____

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 _____

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 _____

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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 _____

COVID Vaccination
Yes _____ No _____

Date of vaccinations:
First Dose _____
Second Dose _____
Booster Dose _____

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

Physicians Signature:_____ Date: _____

Phone 860.887.0684 **99 Washington Street, Norwich, CT 06360** **Fax 860.889.6859**

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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: _____

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Ambulation: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Cane ☐ Walker ☐ Needs Wheelchair

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

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

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

Are there any other medical concerns?

_____

Please list current medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

	Vaccinations	Date Received
COVID	_____	_____
Flu	_____	_____
RSV	_____	_____
Pneumonia	_____	_____
Shingles	_____	_____
Other	_____	_____
Other	_____	_____
Other	_____	_____

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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: _____

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