

Vinland Center

Committed to full lives for people with disabilities.

PHYSICAL EXAMINATION AND MEDICAL HISTORY

Page 1 of 2

To the Physician: Your patient has been referred for admission to the Vinland Center Chemical Dependency Treatment Program. **6** elements are required. **1.** Completion of a history and physical examination. **2.** A tuberculin screening (**Mantoux Test**) is required within **30 days prior to actual admission date** at Vinland Center (page 2). **3.** a statement the client can stake action to preserve their life (page 2). **4.** A statement the client is appropriate to be cared for by non nursing personnel (page 2) and **5** a statement the client is free of communicable disease (page2). **6. This report must be signed by a licensed physician.** (A nurse's signature is not acceptable.) Thank you for your cooperation in fulfilling this requirement. Please call Vinland's Chemical Health Admissions Coordinator (763-479-4508), or Health Services Coordinator (763-479-4503) if we can assist you in any way.

Name of Participant: _____ Date of Exam: _____

ORDERS: _____

1. ADMIT to licensed residential chemical dependency facility.

2. DIET:

- _____ A) Regular
_____ B) Reduced calorie: _____ # of calories per day
_____ C) Diabetic (please specify): _____
_____ D) Low fat / Low cholesterol (< 50 gram fat / < 300 mg cholesterol)
_____ E) No added salts (3 - 5 grams sodium)

3. Vinland Standing Orders approved for PRN medications: _____ Yes _____ No

(Note: Please see enclosed sample copy of Vinland PRN Medication List)

Exceptions: _____

4. Current medications: _____

Recent lab results for medications requiring periodic blood draws:

Medication: _____ Result: _____

Next blood draw due in _____ days

5. Leave of Absence and/or passes away from the chemical dependency treatment facility with medications as approved by the Medical Director.

6. Therapeutic exercise to improve flexibility, strength, endurance, balance and coordination.

Pre Assessment _____

Post assessment _____

Body Mechanics/ergonomics Class _____

8 Individual visits _____

7. Neuropsychological evaluation by a licensed Neuropsychologist _____

8. Diagnostic assessment, psychometric testing and individual therapy by a licensed psychologist. _____

9. Activity Ad Lib: _____ Yes _____ No Exceptions: _____

9. Additional orders: _____

Name of examining physician (please print): _____

Physician's address: _____

Physician's phone #: _____ Physician's fax #: _____

Physician's signature: _____ Date: _____

Note: Please send patients to Vinland with a filled 30 day supply of all medications. All medications must be in a pharmacy container with a pharmacy label.

VINLAND CHEMICAL DEPENDENCY PROGRAM HISTORY & PHYSICAL

Participant Name _____ DOB _____
 Allergies _____ Hgt _____ Wgt _____ B/P _____ P _____ Temp _____
 Current Medications: _____
 Under Physician's Care: Yes No
 Name of Physician/Clinic (printed) _____ Phone _____

MENTAL STATUS

speech appropriate Yes No
 alert Yes No
 good eye contact Yes No
 oriented Yes No

RESPIRATORY

Do you have breathing problems? Yes No
 describe _____
 Do you use tobacco? Yes No
 # of years _____ amount per day _____

***This individual is appropriate for a facility providing
 24-hour non-nursing human service personnel: Yes No

***Mantoux date and results: _____
 (must be within 30 days prior to admission) ***

CHEMICAL USE

Any physical effects from chemical abuse noted: _____

CARDIOVASCULAR

_____ no problem identified _____ high blood pressure
 _____ chest pain _____ heart problems
 _____ other (describe) _____

NEURO

_____ no problem identified _____ headaches
 _____ head injury _____ dizziness
 _____ seizures _____ fainting

GASTROINTESTINAL

_____ no problem identified _____ food restriction
 _____ ulcers _____ bowel problems
 _____ stomach problems _____ weight loss
 _____ hemorrhoids _____ jaundice
 _____ hepatitis
 _____ other (describe) _____

EYES/EARS

_____ no problem identified _____ earaches
 _____ visual acuity _____ hard of hearing
 _____ glasses
 _____ contacts
 _____ other (describe) _____

ENDOCRINE STATUS

_____ no problem identified
 _____ thyroid
 _____ diabetes: _____ juvenile _____ adult
 _____ other (describe) _____

DENTAL/MOUTH

_____ no problem identified _____ tooth decay
 _____ pain _____ abscess
 _____ broken teeth _____ dentures/partial
 _____ bleeding gums _____ plate
 _____ other (describe) _____

MUSCULO-SKELETAL/DERM

_____ no problem identified _____ open wounds
 _____ fractures _____ back problems
 _____ ADLs _____ physical limitations
 _____ pain _____ loss of extremity
 _____ rashes _____ sores
 _____ recent injury
 _____ other (describe) _____
 _____ activity restrictions (describe) _____

GENITAL/URINARY

_____ no problem identified _____ burning
 _____ discharge _____ incontinence
 _____ frequency _____ UTI

IMMUNIZATIONS

Last Td given: _____ Results: _____
 _____ Hep B _____ Other: _____

FEMALE ONLY

LMP _____
 Last pap smear: _____ normal _____ abnormal
 _____ breast (lump, pain, discharge)
 _____ vaginal discharge

SELF PRESERVATION SKILLS

*** In an emergency (fire alarm, gas leak, etc) is this person capable of
 taking appropriate action (getting out of the building) for self
 preservation? Yes No

COMMUNICABLE DISEASE RISK ASSESSMENT

When last tested for STDs/HIV? _____
 Sexually transmitted diseases:
 _____ gonorrhea: treated _____
 _____ chlamydia: treated _____
 _____ syphilis: treated _____
 _____ other: _____
 Communicable disease (such as)
 _____ HIV _____ Hepatitis _____ TB
 _____ Other: _____

DIAGNOSIS:

Axis I: _____
 Axis II: _____
 Axis III: _____
 Axis IV: _____
 Axis V: _____

***Individual is currently free from communicable disease
 YES _____ NO _____

Physician's Signature _____ Date: _____
 Medical Admission review by (Vinland Staff Nurse) _____ Date: _____

STANDING ORDER FOR OVER THE COUNTER MEDICATIONS

NAME _____ ALLERGIES _____

The following maybe given on a PRN basis. Medications contraindicated will be noted by the physician. **Equivalent generic or store brands may be used. Seasonal supplies will be stocked PRN.** Follow all instructions listed. Chart medications administered on the Medication Sheet. Write the reason for giving and the participant's response to the medication in the Health Progress Notes.

FEVER/PAIN/MENSTRUAL CRAMPS

Notify the nurse of a temperature above 100 degrees and pain not relieved by medication.

Tylenol (Acetaminophen) 500 mg Extra Strength tablets (1-2 tablets) q 6 hrs prn **NOT TO EXCEED 8 TABLETS IN 24 HOURS**

Tylenol Elixir (Acetaminophen Elixir) 4 tsp. (650 mg) (o) q 4 hrs prn or

Ibuprofen 200 mg (o) 1-2 tablets or capsules q 4 hrs prn; do not exceed 6 tablets in 24 hrs.

COLD/DISCOMFORT FROM COLD/SORES THROATS

Notify the nurse of temperature above 100 degrees or below 97.6 degrees; if participant has been exposed to strep infection, persistent cough, earache chest pain or congestion; skin rash; or any symptom lasting more than 3 days.

Claritan (Loratadine) 1 tab every 24 hours X 3-5 days PRN 10mg tablets for congestion.

Robitussin DM (Dextromethorphan and Guafensin) (o) 2tsp. q 4 hrs prn cough. Do Not exceed 6 doses in 24 hrs.

Chloraseptic Lozenges (o) for sore throat. Follow directions on package.

CONSTIPATION

Notify the nurse if participant has gone three days without having a BM. Notify the nurse if participant does not have a BM within 24 hours after giving laxative. Under direction of the nurse or MD may give:

Milk of Magnesia (o) 2 tablespoons qd prn. (Usually given at HS)

DIARRHEA

Notify the nurse. Avoid milk products. Give clear liquids. Give clear liquids such as cola, 7-up, Gatorade, Kool-Aid, Popsicle's, tea or apple juice. Under direction of nurse or MD may give:

Imodium (Loperamide) 2 mg (o) 2 capsules or tablets after 1st loose bowl movement, followed by one tablet or capsule after subsequent loose bowel movement. No more than 4 caps per day. Do not use for more than 2 days.

INDIGESTION/NAUSEA/HEARTBURN

Notify nurse or symptoms unrelieved by medication or if vomiting occurs.

Maalox (Alumina and Magnesia) 15 cc (o) q 3-4 hrs prn

POISONING

If participant is unconscious call 911.

If participant is conscious and you suspect poisoning: Call Poison Control immediately. Nationwide 1-800-222-1222 and follow their instructions, then notify nurse/MD.

Administer **Ipecac** only if directed to do so.

MINOR WOUNDS AND BURNS

Notify the nurse if area appears infected; if there is a question about the need for stitches; or if burned area is blistered or skin broken.

Bacitracin Ointment (T) apply to wound 1 to 3 times a day prn. Do not use on a deep or puncture wounds or burns unless directed by physician.

RELIEF OF MILD SUNBURN OR ITCHING

(due to poison ivy/oak, insect bites or other minor skin irritation)

Notify nurse before applying to a rash. Do not to blistered, raw or oozing skin. Discontinue use and notify MD if burning sensation occurs, rash develops, or condition persists after 7 days.

apply **Calamine Lotion** (T) apply liberally 3-4 times a day prn. Shake well. Clean area with soap and water and dry before each application.

RASHES/SKIN IRRITATIONS/SKIN INFLAMMATION

Notify the nurse prior to use. Notify MD if condition worsens or symptoms persist after 7 days.

1% HC Cream (T) apply 3-4 times a day prn. Do not apply to an area larger than 10" by 10" unless directed by MD. Avoid eye, eyelid and oral contact.

ATHLETE'S FOOT

Refer to MD if not improved after 2 weeks. Participant should wash feet daily and dry well.

Encourage use of clean, white cotton socks.

Micatin (Miconazole) (T) apply cream sparingly and massage in well between toes and affected areas in the morning and at bed time.

DANDRUFF

Notify the nurse at next visit if there are severe or patchy areas on the scalp.

Selsun Blue Shampoo (Selenium Sulfide) (T) use 1-2 times per week for dandruff. Shake well before use, lather, rinse and repeat. Rinse well and avoid getting into eyes.

DRY SKIN AND LIPS

Notify the nurse if areas do not respond to treatment in 5 days or if rash develops.

May use non-medicated hygiene/grooming products as indicated or as directed by the nurse.

Carmex (T) apply to lips 2-4 times/day prn for chapping, fever blisters, or cold sores.

PREVENTION

Sunburn - may use any sunblock with a minimum Sunburn Protection Factor of 15. Follow directions on the bottle.

Insect Bites - May use insect repellent as directed on container. Use insect spray with DEET to help protect from Deer Ticks

EPI PENS - If participant identifies self as allergic to bee stings an EPI pen will be available.

OTHER

Benadryl 25-50 mg q 6 h PRN WITH NURSE DIRECTION

Physician Signature _____ **Date** _____

H: Policies CH-Meds

1/07