Lifescape Adult Day Program
1330 S. Alpine Rd.
Rockford, IL. 61108
P: (815) 964-2433
F: (815) 987-1934

Dear Primary Care Provider,

Your patient is currently in the admissions process to attend Lifescape Adult Day Program. To ensure the highest level of quality care, safety and maintaining independence of the patient, an initial physical and TB screening is required.

Enclosed is a physician's form and one-step TB test to be completed prior to the patient's first scheduled day of programming. Please attach the wellness visit summary as well as the most up to date medication list.

Thank you for your prompt assistance with this process, as it helps to keep everyone safe and healthy. If you should have any questions or concerns, please do not hesitate to call me at (815) 964-2433 or fax the completed physical form at (815) 987-1934. Thank you again!

Respectfully,

Kristina Krampota, LPN
Program Nurse Manager

Today's Date: ___________

Lifescape Adult Day Program: Physician's Form

Must be completed and returned to ADP prior to attendance.

Client Name: ______________________________ DOB: __________ Age: ______

Allergies: ____

Height	Weight	Blood Pressure	Pulse	Respiration

Medical Information/Diagnosis (Check all that apply)

Dementia: ☐Alzheimer's ☐Vascular ☐Lewy Bodies ☐Pick's Disease ☐Wernicke-Korsakoff ☐Creutzfeldt-Jakob

Stage: ☐Mild/Early Stages ☐Mid-stage ☐Severe/Late Stage

Diabetes: ☐Type I ☐Type II ☐Insulin ☐Oral ☐Diet Controlled

Cardiac ☐Coronary Artery Disease ☐Arrhythmia ☐Heart Failure ☐Angina ☐Pacemaker ☐Hypertension

Pulmonary ☐Asthma ☐Chronic Bronchitis ☐COPD ☐Emphysema

Stroke ☐CVA __________ ☐TIA __________

Seizures ☐History of Seizures ☐History of Epilepsy

Incontinence ☐Bladder ☐Bowel

Other Medical ☐Arthritis ☐Osteoporosis ☐Parkinsons'

Sensory ☐Hearing Loss ☐Cataracts ☐Glaucoma☐ Macular Degeneration ☐Speech Issues

Psychiatric ☐Depression ☐Anxiety ☐Bipolar Disorder ☐Schizophrenia ☐Hx violent/aggressive behavior

Other Medical Information/Diagnosis (please list or attach list):

____

____

Client Current Medication List

Medications	Dosage	Frequency
*Please attach list		

***Is this client able to self-medicate while at Adult Day Program? ☐Yes ☐Yes with reminders ☐ No**

Medications to be given @ Adult Day Program by Nurses (attach additional sheet if needed)

Medication	Dose	Frequency	Route

ALL MEDICATIONS MUST BE IN NONEXPIRED BOTTLE

Dietary Considerations

*Please check all that apply

☐ NAS (no added salt) ☐NCS (no concentrated sweets) ☐Mechanical Soft ☐Cut Food

Health Maintenance/Immunizations

***Please note: A TB test is required of all clients. Initial TB test must be within the last 30 days of admission.**
Patient must have yearly TB test

TB Test Date: ________________________ **TB Test Results:** ________________________

Influenza Vaccine Date: ____________ (If applicable)

Patient received COVID-19 Vaccine: ☐**No** ☐**Yes**

COVID-19 Vaccine 1st Dose Date: ____________ COVID-19 Vaccine: 2nd Dose Date: ____________

Patient is free of communicable diseases or infections: ☐**Yes** ☐**No***
If no, please state disease or infection: ____

____

Physician Information

Physician Name:	**Please Return this Completed Form to:** **Lifescape Adult Day Program** 1330 South Alpine Rd, Rockford 61108 815-987-1934 (Fax) 815-964-2433 (Phone)
Office Address:	
Office Phone #:	
Office Fax #:	

I certify that I have examined this patient within the last three months and have reviewed patient's health history. I find patient appropriate and able to participate in Lifescape Adult Day Program.

Physician Signature: X ____ Date: ______

Physician Name (Please print): ____

(For Adult Day Program Nurse Use)

Date physician's form received: ________________ Received By: ____________________

Received Via: ☐In person (drop off) ☐Mail ☐Fax ☐Other: ____________

Adult Day Program Nurse Notes:

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State of Illinois
Illinois Department of Public Health

DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ☐ M ☐ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

☐ **Attempt Resuscitation/CPR**
(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

☐ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

☐ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

☐ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

☐ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders ____________________

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

☐ Long-term medically administered nutrition, including feeding tubes.
☐ Trial period of medically administered nutrition, including feeding tubes.
☐ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)
____
____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

☐ Patient
☐ Parent of minor
☐ Agent under health care power of attorney
☐ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)
I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

E — Signature of Attending Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Attending Practitioner Name *(required)*	Phone ( ) ____ - ____
Attending Practitioner Signature *(required)*	Date *(required)*

Form Revision Date January 2015 **(Prior form versions are also valid.)**

IDPH DNR/POLST IDPH DNR/POLST IDPH DNR/POLST IDPH DNR/POLST IDPH DNR/POLST IDPH DNR/POLST

THIS SIDE FOR INFORMATIONAL PURPOSES ONLY

Patient Last Name	Patient First Name	MI

The Illinois Department of Public Health (IDPH) Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment (POLST) **is always voluntary.** This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH Do Not Resuscitate (DNR)/POLST Form

- **The completion of a DNR/POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A DNR/POLST should reflect current preferences of persons completing the DNR/POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a Do Not Resuscitate (DNR)/POLST Form

This DNR/POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR)/POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR/POLST form requires completion of a new DNR/POLST form.
- Draw line through sections A through E and write "VOID" across page if any DNR/POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at http://www.idph.state.il.us/public/books/advin.htm

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

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