Jeremy's Place, Inc.
4910 Old Jonesboro Road (Suite 200)
Union City, GA 30291
770.969.9334 Office 770.969.9337 Fax

PRN Standing Medical Orders

Client:	Date:
Home:	Telephone:

Primary Physician:	Telephone:
Dentist:	Telephone:
Hospital:	Telephone:

Please place check mark in front of all orders that you wish to apply

Symptom	☑	Standing Order
Headache		**Tylenol 325mg-2 tablets P O every four hours as needed for headache pain. If headache Continues over 24 hours call nurse/MD**
		Other:
Skin Breakdown		**Medication:**
		Other:
Constipation		**If no bowel movement for three days increase fluids and fiber, call nurse/MD**
		Other:
Cold Symptoms		**Increase fluids, notify nurse/MD**
		Cleanse wound, apply bandage to open wounds. If applicable complete skin assessment. Notify Supervisor
Minor Abrasions		**Other**
		Other
Notify physician if any of the following occur:		
Physician Signature:		**Date:**

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Seizure Protocol and Management Statement

Name:	**Date:**
Physician:	**Telephone:**

Seizure History:

Medication:

Specific Precautions:

1. Safety Precautions:
2. Consultations: ◊ Neurologist ◊Other

Protocol:

STAY CALM
If client is falling, try to break fall and lower the consumer to the floor.
Do not try to control movements. Do not force an object between teeth.
Document length of seizure. Document types of movements.
Provide first aid if necessary.
Document on Seizure Observation form. Document injuries on Serious/Unusual Incident report.
Notify Program Manager, on-call Program Manager, physician, and family member/guardian
If a status epileptic occurs, call 911
If the seizure lasts more than 3 minutes call 911
If it is client's first seizure call 911
If the client stops breathing call 911 and initiate CPR.
Follow up with physician/neurologist

Recommendations:

Physician Signature/Title: **Date:**

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Diabetic Protocol and Management Statement

Name:	**Date:**
Physician:	**Telephone:**

Diabetic History:

Medication:

Specific Precautions:

1. Safety Precautions:
2. Consultations:

Protocol:

Recommendations:

Physician Signature/Title: **Date:**

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Hypertension Protocol and Management Statement

Name:	**Date:**
Physician:	**Telephone:**

Hypertension History:

Medication:

Specific Precautions:

1. Safety Precautions:
2. Consultations:

Protocol:

Recommendations:

Physician Signature/Title: **Date:**

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Medical Equipment Orders

Client:	Date:
Home:	Telephone:

Physicians:	Telephone:

Please place check mark in front of all orders that you wish to apply

Symptom	☑	Special Instructions
Wheelchair		
Wheelchair safety belts		
Wheelchair safety brakes		
Bed Rails		
Shower Chair		
Gait Belt		
Hoyer Lift		
Bath Chair		
Toilet Chair		
Cane		
Walker		
Other:		
Other:		
Other:		
Other:		
Physician determination for the above order is:		**This equipment is to be used as a safety precaution against falls due to behaviors, seizures, or medical reasons. Duration is ongoing until function changes and the appropriate professional MD/nurse/PT/OT accesses and evaluates and makes recommendations to the MD for further evaluation and orders.**
Physician Signature :		**Date:**

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Cholesterol Protocol and Management Statement

Name:	**Date:**
Physician:	**Telephone:**

Cholesterol History:

Medication:

Specific Precautions:

1. Safety Precautions:
2. Consultations:

Protocol:

Recommendations:

Physician Signature/Title: **Date:**

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Pulmonary Protocol and Management Statement

Name:	**Date:**
Physician:	**Telephone:**

Pulmonary History:

Medication:

Specific Precautions:

1. Safety Precautions:
2. Consultations:

Protocol:

Recommendations:

Physician Signature/Title: **Date:**

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ASPIRATION PROTOCOL

Name:	**Date:**
Physician:	**Telephone:**

Aspiration History:

Description/Symptoms of ASPIRATION (TRIGGERS):

Medications (Dosage/Frequency – must have prescriptions and/Medication orders to administer):

Recommendations (Specific Instructions/Facility Action Plan):

Physician's Signature: _____ Date: _____

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ASTHMA PROTOCOL

Name:	**Date:**
Physician:	**Telephone:**

CALL 911 IF PERSON:

- **IS BLUE OR NOT BREATHING**
- **COMPLAINING OF PAIN AND DISCOMFORT**
- **APPEARS GRAVELY ILL OR YOU ARE CONCERNED ABOUT THEIR IMMEDIATE HEALTH AND SAFETY**

_____OTHER_____

1. **Start emergency procedures as trained.**
2. **Notify _____ Supervisor _____ Case Manager _____ Physician _____ Nurse _____ Other _____**
3. **After the person is stable document incident in: _____ Medical Notes _____ Incident Report _____ Other**

Asthma History:

Description/Symptoms of Asthma:

Medications (Dosage/Frequency – must have prescriptions and/Medication orders to administer):

DOSAGE/PUFFS
DOSAGE/PUFFS
DOSAGE/PUFFS

Recommendations (Specific Instructions/Facility Action Plan):

Physician's Signature: _____ Date: _____

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FALL PROTOCOL

Individual Name: _____ Date of Birth _____

Address: _____

FALL/GAIT History:

_____

_____

_____

_____

Description/Symptoms of FALL/GAIT (Triggers):

_____

_____

_____

_____

Medications (Dosage/Frequency – must have prescriptions and/Medication orders to administer):

_____

_____

_____

_____

Specific Instructions/Facility Action Plan:

_____

_____

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

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Bowel Care Protocol

Name:	**Date:**
Physician:	**Telephone:**

Bowel History:

Medication:

Specific Precautions:

1. Safety Precautions:
2. Consultations:

Recommendations:

Physician Signature/ Title:	**Date:**

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GERD PROTOCOL

INDIVIDUAL NAME: _____ Date of Birth: _____

Address: _____

GERD History:

Description/Symptoms of GERD:

Medications (Dosage/Frequency – must have prescriptions and/Medication orders to administer):

Recommendations (Specific Instructions/Facility Action Plan):

Physician's Signature: _____ Date: _____

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SKIN PROTOCOL

INDIVIDUAL NAME: _____ Date of Birth: _____

Address: _____

SKIN breakdown history:

_____

_____

_____

_____

Description/Symptoms of SKIN breakdown:

_____

_____

_____

_____

Medications (Topical/Dosage/Frequency – must have prescriptions and/Medication orders to administer):

_____

_____

_____

_____

Recommendations (Specific Instructions/Facility Action Plan):

_____

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

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Name _____
DOB _____

Tuberculosis Skin Test Reading

Date Administered:	**Location Administered:**
Date of Reading:	**Result of Reading:**

Comments: _____

_____

_____

_____ _____

Physician or Nurse Signature/Title Date

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JEREMY'S PLACE, INC.

Physical Form: _____ INDIVIDUAL/MEMBER _____ EMPLOYEE _____ VOLUNTEER

Name		**Date**			
		DOB		**Age**	

Height		Weight		Blood Pressure			Pulse		LMP	

PROBLEMS ADDRESSED	MEDICATIONS	RXS WRITTEN

RISK FACTORS REVIEWED	
1.	Diet
2.	Exercise
3.	Safety (seat belts, smoke detectors, firearms, violence)
4.	Smoking
5.	Alcohol and other drugs
6.	STDs/Contraception
7.	Advanced Directive

DISEASE PREVENTION AND RECOMMENDATIONS	
1.	Stroke and coronary disease (BP, cholesterol, weight, stress, aspirin – 81 mg./day)
2.	Cancer (diet, vitamin C – 500 mg., E – 400 units)
3.	Osteoporosis (exercise, calcium 1500 mg., vitamin D – 400 units, estrogen)
4.	Viruses and colds (wash hands, vitamin C – 500-1000 mg., Echinacea, fluids, zinc)
5.	Other

HEALTH MAINTENANCE (enter date, or √ if done today, or WS for "will schedule")							
Immunizations	Td	Flu	Pneumovax		Hep.B	Hep.C	Varicella
Lab	CBC	Chem	TSH	PSA	Lipid Profile		
	U/A		Hemoccults		Other		
Pap			GC/CT				
Mammogram			Bone density				
Flex. Sig.			Treadmill				

OTHER RECOMMENDATIONS/REFERRALS	
Follow up	Next Physical

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Name		**Date**			
		DOB		**Age**	

ADDITIONAL HISTORY DISCUSSED			
☐ Update family history		☐ Update surgeries	
ROS	☐ HEENT	☐ Gastrointestinal	☐ General
	☐ Cardiovascular	☐ Genitourinary	☐ Psychiatric
	☐ Respiratory	☐ Neuromuscular	☐ Derma.

PHYSICAL EXAM				
Head		Heart	Extremities	
Eyes		Lungs	Scrotum	
Ears		Breasts	Penis	
Nose		Abdomen	Hernia	
Throat		Vulva	Prostate	
Thyroid		Vagina	Rectal	
Nodes		Cervix		
Carotids		Uterus		
Skin		Adnexa		

Physician's Signature _____