PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY:		TELEPHONE:
`California Family Life Center FFA		951-654-2352
ADDRESS: NUMBER STREET	CITY	
P.O. Box 727 Hemet, CA 92546-709		
LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:
		336 403 709

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:		TELEPHONE:
ADDRESS: NUMBER STREET	CITY	SOCIAL SECURITY NUMBER:
NEXT OF KIN:	PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS:				LENGTH OF TIME UNDER YOUR CARE:
AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO
TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE				DATE OF LAST TB TEST:
TYPE OF TB TEST USED:				TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:	TREATMENT/MEDICATION:
A) ☐ YES ☐ NO If YES, list below:	B) ☐ YES ☐ NO If YES, list below:
ALLERGIES	TREATMENT/MEDICATION:
C) ☐ YES ☐ NO If YES, list below:	D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**	COMMENTS:			
	YES	**NO** *(Check One)*	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**	COMMENTS:			
	NO PROBLEM	**OCCASIONAL**	**FREQUENT**	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ **YES** ☐ **NO**	COMMENTS:		
	YES	**NO** *(Check One)*	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE:

CALIFORNIA FAMILY LIFE CENTER
FOSTER FAMILY AGENCY

OVER-THE-COUNTER MEDICATION ORDER

Dear Dr. _____

RE: _____ DOB: ____/____/____

Facility/Home: _____ Order valid from: _____

According to California Licensing Regulations, over-the-counter medications cannot be administered to the above named child without his/her physician's approval. To ensure optimal health care to this child, please review the two (2) attached pages and **indicate which medications you approve** being administered on an "as needed" (PRN) basis **by initialing in the space provided next to the medication**.

The child's doctor should always be notified if the child is sick or experiences persisting symptoms.

If the child's primary physician should change during the course of placement, the current attending physician must sign a new order.

This order is valid for one year unless otherwise specified by the physician or there is a change in the primary care physician.

PLEASE INDICATE:

[ ]This client is able to communicate his/her need for these medications

[ ]This client is able to communicate his/her symptoms.

PRINT: Doctor's Name: _____

Medical License No.: _____

Office Address: _____

City: _____ Zip: _____

Phone: (____) _____

Doctor's Signature _____ Date Signed: _____

FORM IS INVALID WITHOUT DOCTOR'S NAME, ADDRESS, LICENSE #, SIGNATURE, AND DATE

REVISED 3/11 – All versions prior to this (or undated versions) are invalid and should be destroyed.

Child's Name:_____

OVER THE COUNTER MEDICATIONS--DOSAGE INFORMATION

Dr. Initials	Medication	Reason for Administration	Dosage		
	Children's Tylenol / Children's Acetaminophen	For fever over 100-101.9° F or for mild to moderate muscular/skeletal pain or headache. For fevers 102-102.4°, see information on Ibuprofen below. *For fevers 102.5° and above, contact your physician or take the child to urgent care. For infants 0-3 months, any fever over 100° requires medical attention.* ***Dosage information*** *: Do not exceed 5 doses in 24 hours.*	Infant Drops	0-3 mos (6-11 lbs) 4-11 mos (12-17 lbs) 12-23 mos (18-23 lbs)	0.4ml every 4 hrs 0.8ml every 4 hrs 1.2ml every 4 hrs
			Elixir/liquid	4-11 mos (12-17 lbs) 12-23 mos (18-23 lbs) 2-3 yrs (24-35 lbs) 4-5 yrs (36-47 lbs) 6-8 yrs (48-59 lbs) 9-10 yrs (60-71 lbs) 11-12 yrs (72-95 lbs)	½ tsp every 4 hrs ¾ tsp every 4 hrs 1 tsp every 4 hrs 1 ½ tsp every 4 hrs 2 tsp every 4 hrs 2 ½ tsp every 4 hrs 3 tsp every 4 hrs
			Tablets (80 mg)	2-3 yrs (24-35 lbs) 4-5 yrs (36-47 lbs) 6-8 yrs (48-59 lbs) 9-10 yrs (60-71 lbs) 11yrs (72-95 lbs) 12+ yrs (96 lbs +)	2 tabs every 4 hrs 3 tabs every 4 hrs 4 tabs every 4 hrs 5 tabs every 4 hrs 6 tabs every 4 hrs 400-650 mg every 4 hours
	Regular Strength Tylenol / Acetaminphen (adult strength-325 mg)	For children over 12 experiencing fever of 100-101.9°.	Tablets (325 mg)	12+ years	2 tablets every 4-6 hours
	Children's Advil / Motrin / Ibuprofen (100mg/5mL)	For fevers 102-102.4° or for mild to moderate pain. ***Dosage information:*** *Not to exceed 5 doses in 24 hours.*	Elixir/liquid	12-23 mos (18-23 lbs) 2-3 yrs (24-35 lbs) 4-5 yrs (36-47 lbs) 6-8 yrs (48-59 lbs) 9-10 yrs (60-71 lbs) 11-12 yrs (72-95 lbs)	1 tsp every 4-6 hrs 1 ½ tsp every 4-6 hrs 2 tsp every 4-6 hrs 2 ½ tsp every 4-6 hrs 3 tsp every 4-6 hrs 3 ½ tsp every 4-6 hrs
	Advil / Motrin (adult strength-200mg)	For children over 12 years and over 95 pounds experiencing mild to moderate pain or menstrual cramps ***Dosage information:*** *Not to exceed 6 tablets in 24 hours.*	Tablets	12+ years	1 tab every 4-6 hours
	***Children's Dimetapp**	For runny nose	For each of the medications listed to the left:		
	***Robitussin DM**	For coughs			
	***Robitussin CF**	For cough and runny nose	Elixir/liquid	1-3 yrs (24-36 lbs) 4-5 yrs (37-49 lbs) 6-8 yrs (50-62 lbs) 9-11 yrs (63-95 lbs) 12-17 yrs (96+ lbs)	½ tsp every 4 hrs ¾ tsp every 4 hrs 1 tsp every 4 hrs 1 ½ tsp every 4 hrs 2 tsp every 4 hrs
	***Benadryl (liquid)**	For congestion, allergy symptoms, itching or swelling from insect bites			
*	**Triaminic/Generic for above 4 medications**	***Dosage information:*** *Not to exceed 6 doses in 24 hours.*			

Child's Name:_____

OVER THE COUNTER MEDICATIONS--DOSAGE INFORMATION

Dr. Initials	Medication	Reason for Administration	Dosage	
	Antacid Tablets (Calcium Carbonate)	For relief of excess stomach acid	Chew 1-2 tablets as needed. Do not exceed more than 16 tablets in a 24 hour period	
	Children's Mylanta or Children's Maalox	For upset stomach in children 2-11 years	2-5 yrs (24-47 lbs)	1 tsp every 8 hrs *Do not exceed 3 tsp in 24 hrs*
			6-11 yrs (48-95 lbs)	2 tsp every 8 hrs *Do not exceed 6 tsp in 24 hrs*
	Mylanta / Maalox (Adult Strength)	For stomach upset in children 12+ years	12+ yrs	1 tsp 4 times a day *Do not exceed 6 doses in 24 hrs*
	Cloraseptic/Generic	For sore throat pain. Not to be used by children under 2 years of age. If conditions persist, contact physician.	2-11 yrs	3 sprays and swallow every 2 hours
			12 yrs to adult	5 sprays and swallow every 2 hours
	Pedialyte	To prevent dehydration from diarrhea and vomiting during illness *If diarrhea, vomiting, or fever continues beyond 24 hours, if child has bloody stool, or if child is under 2 years, contact physician*	2+ yrs	2 liters per day while diarrhea/vomiting continues.
	Calamine / Aveeno anti-itch cream / generic	For itchy skin.	2+ yrs	Use 4 times daily as needed.
	Hydrocortisone 1%	For itchy skin in children 12+ years. Do not use on face	12+ yrs	Use 4 times daily as needed.
	Micatin / Lotrimine / Tinactin / Cruex	Spray: For jock itch	Clean area and dry thoroughly. Apply morning and night. *Do not use more than 2 weeks.*	
		Cream: For athletes food, ringworm, or yeast diaper rash	Apply to affected area 3 times daily. *Do not use more than 2 weeks.*	
	Neosporin / Triple Antibiotic Ointment	For cuts and abrasions. *For deep or serious cuts, consult physician*	Apply to affected area. Use as often as needed to prevent infection.	
	Nix / Rid	For treatment of head lice. *Do not use in children under 2 years*	2+ yrs	Apply to hair for 10 minutes. Rinse thoroughly. Remove nits with nit comb. Retreat in 10 days.
	Orasol / Ambesol	For relief of gum, mouth, or teeth pain and for teething infants 4 mos or older *Do not use for more than 7 days.*	4+ mos	Apply to affected area up to 4 times daily.