



**CHIMES Day Programs
PHYSICIAN'S MEDICATION ORDER FORM**

Name of Person Served: _____

Diagnosis: _____

Allergies: _____

Medication/Treatment				
Dosage				
Hours/Frequency of Dosage				
Method of Administration Of Medication/Treatment				
Reason for Medication/Treatment				
Stop Date				
Possible Side Effects				
Healthcare Professional to Contact for Following Condition				

Diet Consistency, Solids: _____ Mechanical Soft, including raw fruits & vegetables _____ Mechanical Soft, no raw fruits and vegetables and/or hard foods

Diet Particle Size: ___ Regular ___ Cut to bite size ___ Fine Chopped (soft food **fine chopped** in food processor) ___ Pureed (soft food **pureed** in food processor)

Diet Consistency, Liquids: ___ Thin (consistency of water) ___ Nectar (coats and drips off spoon) ___ Honey (flows off spoon in a ribbon ___ Pudding (stays on spoon in soft mass: plops off spoon)

Diet, Prescribed Calorie Count: _____ 800 _____ 1200 _____ 1500 _____ 1700(Regular) _____ 1800ADA _____ 2200 _____ 3000

Other Diet Restrictions: _____

Person Served Uses Following Adaptive Equipment: _____

May Attend Program _____ days per week

Physician Name (Please Print) _____ **Physician Signature:** _____

Address: _____ **Phone #** _____ **Date:** _____

This Form Must Be Completed Whether Person Served Is On Medication Or Not