



RULE OUT TB

All of our participants and staff at the Creative Living Center need to have a PPD skin test/CXR to rule out TB, annually.

For participants who have a history of a positive TB skin test and have had a CXR to r/o TB, their CXR does not need to be repeated annually unless they are otherwise symptomatic and have had a current TB screening by their physician. Please include a copy of their TB screening.

Please complete below and return to our Center. Thank You.

Name: _____ **DOB:** _____

Date PPD administered **Time**

Site Location

Administered by: Signature/Title

Results **Time and date when read**

Results read by: Signature/Title



CREATIVE
LIVING CENTER

RECORD OF TUBERCULOSIS SCREENING

NAME: _____ DOB: _____

SEX: Male / Female RACE: _____

Answer the following questions:

DO YOU HAVE:	DESCRIPTIONS	YES	NO
1. Unexplained productive cough?	<i>Cough greater than 3 weeks in duration</i>		
2. Unexplained fever?	<i>Persistent temperature elevations greater than one month</i>		
3. Night sweats?	<i>Persistent sweating that leaves sheets and bedclothes wet</i>		
4. Shortness of breath or Chest pain?	<i>Presently having shortness of breath or chest pain</i>		
5. Unexplained weight loss or appetite loss?	<i>Loss of appetite with unexplained weight loss</i>		
6. Unexplained fatigue?	<i>Very tired for no reason</i>		

The above health statement is accurate to the best of my knowledge. I will see my doctor and/or the health department if my health status changes.

Signature/Patient Date

Signature/Witness Date

This is to certify that the above named person had a tuberculin skin test on _____(date) which was read as _____mm, and had a chest X-ray done on _____(date) which showed no sign of active inflammatory disease. This person has no symptoms suggestive of active tuberculosis disease. A chest X-ray for tuberculosis is not indicated.

Signature/Licensed Medical Professional **Date**

Source: NCDHHS, Division of Epidemiology Tuberculosis Control, March 2002.



STANDING ORDERS

PRN MEDICATIONS AND PROCEDURES

901 Staton Road ~ Greenville, NC 27834 ~ (252)757-3344 ~ Fax (252)757-9615

NAME: _____ **DOB:** _____

PHYSICIAN: _____ **PH#:** _____

____ **1. FOR FEVER UP TO 101:**

- a. Tylenol 500mg 1-2 tabs po every 4-6 hrs.
- b. Monitor temperature in one hour after administration, then every 4 hrs (while at CLC) and prn.
- c. Temp 101 or greater, notify physician.

____ **2. FOR HEADACHE AND/OR MINOR DISCOMFORT:**

- a. Tylenol 500mg 1-2 tabs po every 4-6 hrs, up to 3 doses within a 24 hr period.
- b. Notify physician if pain persists.

____ **3. FOR COUGH/CONGESTION WITHOUT FEVER:**

- a. Robitussin 2 tsp (10cc) po every 4-6 hrs, prn for 3 days.
- b. Notify physician if cough persists more than 3 days.

____ **4. FOR CONSTIPATION:**

- a. Milk of Magnesia 2 TBSP (30cc) po.
- b. Fleets/soapsuds enema prn for constipation if not relieved by MOM.

____ **5. FOR DIARRHEA:**

- a. Kaopectate 2 TBSP (30cc) po after each loose stool, up to 6 doses in 24 hrs.
- b. Notify physician if problem persists.

____ **6. FOR ALLERGIC REACTION:**

- a. Benadryl 25mg 1-2 tabs po every 4 hrs prn, up to 6 doses in 24 hrs.
- b. Notify physician if reaction persists.

____ **7. FOR MINOR INSECT BITES, ITCHING OR RASH:**

- a. Hydrocortisone cream 0.5%, apply to area topically every 6 hrs prn.
- b. Notify physician if problem persists.

____ **8. FOR HEARTBURN OR INDIGESTION:**

- a. Maalox 2 TBSP (30cc) po up to 4 times in 24 hrs.
- b. Notify physician if problem persists.

____ **9. FOR GENERAL FIRST AID:**

- a. Skin tear:
 - Dressing change bid until healed, as follows:
 - Clean with soap and H2O or NS.
 - Pat dry then approximate skin edges gently.
 - Apply Neosporin antibiotic ointment sparingly.
 - Apply a non-adherent dressing.
 - Secure with 4 x 4 gauze and tape.
 - Apply a bandaid for abrasion or minor tear.
- b. Notify physician if signs and symptoms of infection.

____ **10.VS AND WEIGHT EVERY MONTH.** Notify physician of abnormalities or as indicated (parameters for notification): _____

____ **11.FSBS EVERY MONTH AND PRN IF DIABETIC** (parameters for notification): _____

____ **12.PO MEDICATIONS MAY BE CRUSHED** and/or placed in applesauce or juice, if not “time released.”

____ **13.GENERIC DRUG EQUIVALENT** may be used unless otherwise noted.

____ **14.MAY GIVE PO MEDICATION PER GASTROSTOMY TUBE** as indicated.
Flush with 30cc of H2O before and after medication administration.

____ **15.EXCEPTIONS:** _____

____ **16.OTHER ORDERS:** _____

ALLERGIES (please note): _____

Physician signature

Date



CREATIVE
LIVING CENTER

DIET ORDER

CLIENT NAME: _____ **PHYSICIAN:** _____

DOB: _____ **ALLERGIES:** _____

The following diets are the only diets available to the clients of Creative Living Center, through Cypress Glen Dietary Department. We can only ensure that the diet ordered will be followed while the client is at the Creative Living Center.

PLEASE CHECK ALL THAT APPLY:

____REGULAR

____MECHANICAL SOFT

____PUREED

____NAS (no added salt)

____NCS (no concentrated sweets)

____1800 CAL

____NAS/NCS (no added salt/no concentrated sweets)

____LOWFAT/CHOL

COMMENTS:

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Effective 1/1/02TDS
Retyped 6/06cf

Please have the participant's physician fill out an FL2 form before scheduling a pre-admission assessment. If you need an FL2 form or your physician does not have forms, please contact us and we will mail the form to you, or you can pick up a form at CLC.

Thanks!