Fax Cover Sheet

To: 620-792-4709
From: Dr. Ayre's Office- Eyecare of Great Bend
From Number: 620-792-3534
Date: 09/04/2024
Page Count: 2
Memo: Iola Titsworth

To: Dr. Ayre
RE: Iola Titsworth

In order to satisfy state and agency requirements we need the following items:

1. Please indicate the diagnosis for the medications that you prescribe:

   Betimol Sol. 1 drop in each eye BID- **Glaucoma**

2. Does Iola have an order for a special diet? **Yes**
   What is the reason/diagnosis for the diet? **Low body weight**
   Please list what the special diet is: **Takes Mirtazapine daily and Boost when needed. Also encouraged to eat higher calorie meals**

3. Is this client incontinent? **Yes**
   If yes, what is the disability that contributes to or causes incontinence? **Overactive Bladder**

4. What is Iola's primary disability diagnosis? **Mild Intellectual Disorder, COPD, Glaucoma, GERD, Hyperlipidemia, Osteoporosis, Hyperthyroidism, Overactive Bladder, Low Body Weight**

Provider's signature _____

SUNFLOWER DIVERSIFIED SERVICES

PO Box 838

GREAT BEND, KANSAS

PHONE # 620-792-1321 FAX # 620-792-4709

Medical Conditions, Diagnosis and Prescription Medications

Client/Patient: **Iola Titsworth**

DOB: **7/7/51**

Client/Patient currently have a medical condition/diagnosis or taking prescribed medications for the following:

Respiratory:

Cardiovascular:

Gastro-Intestinal:

Genito-Urinary:

Neoplastic Disease:

Neurological Disease:

Antipsychotic:

Antianxiety:

Antidepressant:

Anti-Convulsant:

Diabetes:

Sedative/Hypnotic:

Other Prescription Maintenance Medication: **Betimol Solution (Glaucoma)**

Please sign below if information is correct and true based on your professional knowledge and judgment.

_____ Date 9/3/24