

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 Titworth

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 _____

A handwritten signature in black ink, appearing to be a stylized 'K' or similar, written over a horizontal line.



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