PATIENT HISTORY AND PHYSICAL for ADULT DAY HEALTH CARE / COMMUNITY BASED ADULT SERVICES

Center Name: ***Inland Empire ADHC/CBAS*** **Center Tel:** ***951.808.9600*** **Center Fax:** ***951.808.9178***

Address: ***135 North McKinley Street Corona, CA 92879***

Patient Name: ______________________________ M ☐ F ☐ **DOB:** ____________________ **Last Exam Date** ___/___/____

DIAGNOSES / CONDITIONS reflecting the patient's health status (Complete or attach electronic health record (EHR)

PRIMARY DIAGNOSIS (REQUIRED):

Neuro / Cognitive
☐ Alzheimer's disease ☐ Other Dementia's ☐ CVA
☐ Intellectual Disability
☐ Neuropathy ☐ Parkinson's ☐ Seizures
☐ Other:

Cardiovascular
☐ Arrhythmia ☐ A-fib ☐ Anemia ☐ Angina
☐ CAD ☐ CABG ☐ CHF
☐ HTN ☐ MI ☐ PVD
☐ Other:

Endocrine / Metabolic
Diabetes Mellitus: ☐ (Type 1) ☐ (Type 2)
☐ Hyperlipidemia ☐ Neuropathy ☐ Nephropathy
☐ Hypothyroidism ☐ Hyperthyroidism
☐ Retinopathy ☐ Other:

Musculoskeletal
☐ Chronic Back Pain ☐ Joint Replacement
☐ Osteoarthritis ☐ Osteoporosis
☐ Spinal Stenosis ☐ Gout
☐ Other:

Pulmonary / Respiratory
☐ Asthma ☐ Chronic Bronchitis
☐ COPD ☐ Emphysema
☐ Other:

Gastrointestinal / Genitourinary
☐ Chronic Liver Disease ☐ Chronic Kidney Disease
☐ GERD ☐ Hemorrhoids ☐ PUD ☐ BPH ☐ UTI
☐ Other:

Behavioral Health
☐ Anxiety ☐ Bipolar ☐ PTSD ☐ Depression
☐ Schizophrenia
Other:
Name of other treating MD, if known:_____________

Other Conditions
☐ Cataracts ☐ Difficulty Swallowing ☐ Insomnia
☐ Glaucoma ☐ Hearing Loss ☐ Low Vision
☐ Skin Breakdown ☐ Aphasia ☐ Ataxia
☐ Other:

PHYSICAL EXAMINATION (Complete or Attach EHR)

Comments	Comments
HEENT	**Gastrointestinal** ☐ Incontinence Bowel
Respiratory	**Genitourinary** ☐ Incontinence Bladder
Cardiovascular ☐AICD ☐Pacemaker	**Musculoskeletal**
Breast / Chest	**Integumentary**
Neurological	**Significant Physical Limitations**

Temp: **Pulse:** **Resp Rate:** **BP:** **Height:** **Weight:**

TB SCREENING (required by law within last 12 months)
PPD Date: / / Result: ***OR*** **CXR Date: / / Result:**
If no TB Screening w/in past 12 months, PCP authorizes Center to place PPD.
☐ **If checked, Center requests PCP to complete PPD and record results.**

Allergies *(Medication & Environment):*

MEDICATION PROFILE (Complete or Attach EHR)

Medication	Dosage	Route	Freq	Medication	Dosage	Route	Freq
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

© CAADS 2013. All rights reserved.

PATIENT HISTORY AND PHYSICAL for ADULT DAY HEALTH CARE / COMMUNITY BASED ADULT SERVICES

Patient Name: ____

1. Unsteady Gait? ☐Yes ☐No
2. Any known history of falls? ☐Yes ☐No
3. Medication non-compliance? ☐Yes ☐No
4. Recent hospitalization? (w/in 6 months) ☐Yes ☐No
5. Any significant medical history? ☐Yes ☐No
6. Any known evidence of communicable disease? ☐Yes ☐No

Please describe any "Yes" answers if details are known:

STANDING ORDERS (*PCP, please strike through any orders not approved and write in alternate orders, as desired*)

Acetaminophen 325 mg 1tab PO Q4 hours prn mild pain or 2 tabs PO Q4 hours prn moderate - severe pain
Acetaminophen 500 mg 1tab PO Q4 hours prn mild pain or 2 tabs PO Q4 hours prn moderate - severe pain
Annual influenza virus vaccine injection per CDC recommendations *(if offered at ADHC/CBAS center)*
OTC Antacid Name: MYLANTA 30cc per package instructions for indigestion
Emergency O2 at 2 or 4 L/min. nasal cannula prn
Ibuprofen 200 mg 1tab PO Q4 hours prn mild pain w/ food or 2 tabs PO Q4 hours prn moderate-severe pain w/ food
Loperamide 2 mg PO as per package directions prn diarrhea
Minor wound protocol: cleanse w/ normal saline; apply antibiotic ointment; cover with dry dressing prn
Non-enteric coated ASA 81 mg per MI protocol PO 1X
Tuberculin PPD 0.1 mg ID in forearm Read 48-72 hours *(if no screen within last 12 months and if test offered at ADHC/CBAS center)*
Do Not Resuscitate Order on File: ☐ **Yes** ☐ **No**
Additional or Alternative Orders:

VITAL PARAMETERS	DIET ORDERS
MD may adjust by striking thru and entering desired parameter(s)for notification.	☐ Regular Diet ☐ Cardiac Diet ☐ Diabetic Diet ☐ Renal Diet ☐ Other:____________________
Systolic Blood Pressure: 80 - 170	Center may deviate from No Concentrated Sweets diet order up to two times a month (special occasions)
Diastolic Blood Pressure: 50 - 110	**DIET TEXTURE:**
Pulse: 50 -110	☐ Regular ☐ Chopped ☐ Puréed ☐ Thickened Liquids ☐ Other:____________________
Random Blood Glucose: 60 - 300	Any known food restrictions? ☐ Yes ☐ No Specify:

PLEASE SPECIFY FREQUENCY AND PARAMETERS OF BLOOD SUGAR MONITORING:

BLOOD SUGAR CHECKS: Blood glucose testing will be done 1x/week before lunch at Center for non-insulin dependent diabetics, unless otherwise specified: ____

BLOOD SUGAR PARAMETERS:

Please give Blood sugar parameters for **when to notify you via phone call (and followed up via fax)**: **Low:**__________ **High:**__________

Please give Blood sugar parameters for **when you wish to have Ptp. sent to the Emergency Room**: **Low:**__________ **High:**__________

REQUEST FOR ADULT DAY HEALTH CARE / CBAS SERVICES SECTION (must be completed and signed by PCP)

All patients receive the following on each day of attendance: skilled nursing, social services (PRN), personal care (PRN), therapeutic activities and meal services. Additional services, provided as needed, include physical therapy, occupational therapy, speech therapy, mental health services and transportation, based on multidisciplinary team assessment. ADHC / CBAS services are ongoing unless otherwise indicated.

1) Indicate contraindications for receiving any of the above additional services: ☐ None

If so, explain____

2) Are there any medical contraindications for one-way transportation more than 60 minutes? ☐ None

3) Overall health prognosis?____

4) Overall therapeutic goals?____

This patient has one or more chronic or post-acute conditions that require monitoring, treatment or intervention, without which there is a high potential for further deterioration and may require emergency room, hospitalization or institutionalization. **The information provided reflects this patient's current health status. I request ADHC / CBAS services in addition to authorizing the standing orders.**

Print PCP Name: ____

PC Signature:______________________________**Date:**____________________

PCP Phone Number:____________________**PCP Fax Number:**____________________

Inland Empire ADHC/CBAS
135 N. Mc Kinley Street
Corona CA 92879
Phone: (951) 808-9600 Fax: (951) 808-9178

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The undersigned authorizes the release of the medical information concerning ___________________ (name of participant) to the **Inland Empire ADHC/CBAS Center**

The undersigned also authorizes the release by **Inland Empire ADHC/CBAS** of the psychiatric information to other health care providers, agencies, or individuals who may provide psychiatric or social services.

This authorization is limited to pertinent psychiatric information concerning the above-named individual.

This authorization shall remain valid as long as the person remains enrolled at **Inland Empire ADHC/CBAS** and I understand that I may revoke this authorization at any time.

The undersigned is the participant, spouse, legal guardian, or person financially responsible for the participant.

The undersigned has the right to receive a true copy of the authorization upon request. By placing his/ her initials to the left of this clause on the original authorization, the undersigned acknowledges that a true copy of this authorization has been received.

A copy of this authorization is as valid as the original.

Participant's Name: ____________________________

____
Signature of Participant / Legal Rep.

____
Date