# MountainView ADHC, Inc.

23751-57 Roscoe Blvd., West Hills, CA 91304
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## PATIENT HISTORY AND PHYSICAL FOR ADULT DAY HEALTH CARE / COMMUNITY BASED ADULT SERVICES

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

Center Name: MOUNTAINVIEW Adult Day Health Care Center Tel: 818-999-9234 Fax: 818-716-8030 or 888-640-1718

Address: 23751 ROSCOE BLVD, WEST HILLS, CA 91304

☐ **EHR attached (If EHR is attached, bypass any related sections below)**

## Section A. DIAGNOSES / CONDITIONS reflecting the patient's health status

***PRIMARY DIAGNOSIS (REQUIRED):**_____ *** Include ICD-10 Code. Check all that apply below.**

**SECONDARY DIAGNOSIS:** _____

**Central Nervous System Diseases (G00-G99)**

☐ Parkinson's disease ☐ Cerebral palsy
☐ Alzheimer's disease ☐ Seizure disorder
☐ TIAs & related syndrome ☐ Cerebrovascular disease
☐ Idiopathic neuropathy ☐ Hydrocephalus
☐ Hemiplegia/hemiparesis
☐ Other nervous system (specify): _____

**Diseases of the Circulatory System (I00-I99)**

☐ Hypertension ☐ A-fib ☐ MI ☐ Angina
☐ Arrhythmia ☐ PVD ☐ CHF
☐ Pulmonary heart disease ☐ Atherosclerosis
☐ Other circulatory (specify):_____

**Endocrine, Nutritional & Metabolic Diseases (E00-E89)**

☐ Diabetes Mellitus
☐ (Type 1) ☐ (Type 2) with complications:
☐ Retinopathy ☐ Neuropathy ☐ Nephropathy
☐ Other_____
☐ Hyperlipidemia ☐ Hyperthyroidism
☐ Hypothyroidism ☐ Nutritional Deficiency
☐ Other Metabolic Disorder (specify):_____

**Diseases of Musculoskeletal/Connective Tissues (M00-M99)**

☐ Rheumatoid Arthritis ☐ Osteoarthritis
☐ Gout ☐ Osteoporosis
☐ Joint replacement _____
☐ Other musculoskeletal disorder (specify): _____
☐ Other connective tissue disorder (specify):_____

**Pulmonary / Respiratory Diseases (J00-J99)**

☐ Asthma ☐ Chronic Bronchitis
☐ COPD ☐ Emphysema
☐ Other respiratory/pulmonary diseases (specify): _____

**Diseases of Digestive (K00-K95) & Genitourinary (N00-N99) Systems**

☐ Chronic Liver Disease ☐ BPH
☐ Hemorrhoids ☐ GERD
☐ Liver disease ☐ Peptic Ulcer ☐ Chronic UTI
☐ Chronic Kidney Disease Stage ____ ☐ Other digestive & genitourinary (specify): ____

**Mental, Behavioral & Neurodevelopmental Disorders**

☐ Anxiety ☐ Bipolar ☐ Depression
☐ Developmental delay w/ behavioral symptoms
☐ Schizophrenia ☐ Agitation
☐ Unspecified dementia (pre-senile, senile, primary degenerative)
☐ Other behavioral & emotional disorder (specify):_____

**Other Conditions**

☐ Cataracts ☐ Macular degeneration ☐ Insomnia
☐ Glaucoma ☐ Hearing loss ☐ Low vision/blind
☐ Skin breakdown ☐ Ataxia ☐ Aphasia
☐ Other conditions (specify): _____

## Section B. RISK FACTORS

Unsteady gait? ☐ Yes ☐ No
Hx of falls? ☐ Yes ☐ No
Hx of communicable disease? ☐ Yes ☐ No
Recent hospitalizations? (w/n 6 mo's) ☐ Yes ☐ No
Medication management? ☐ Yes ☐ No
IF NO, is patient able to self-administer at the Center? ☐ Yes ☐ No

## Section C. DIET ORDERS

Any known food restrictions or food allergies? ☐ Yes ☐ No _____
☐ Regular (no added salt/ added fat ☐ No concentrated sweets (NCS) ☐ Low fat
☐ Other (specify): _____

☐ Regular texture ☐ Chopped ☐ Mechanical soft/finely chopped ☐ Pureed
☐ Thickened Liquids: ☐ Yes ☐ NO IF Yes, *consistency:* ☐ Nectar-thick
☐ Honey-thick ☐ Pudding-thick
☐ NPO, G/J-Tube Feedings:_____ formula/ amount/day)

Patient Name:_____ DOB:____/____/_____

**Section D. CURRENT MEDICATIONS** (If EHR is attached, bypass Medication Section below) (Center will conduct medication reconciliation and report inconsistent findings to MD)

| Medication | Dosage | Route | Freq | Medication | Dosage | Route | Freq |
|---|---|---|---|---|---|---|---|
| 1. | | | | 5. | | | |
| 2. | | | | 6. | | | |
| 3. | | | | 7. | | | |
| 4. | | | | 8. | | | |

**Section E. PHYSICAL EXAMINATION**

| Comments | Comments |
|---|---|
| **HEENT** | **Gastrointestinal** ☐ Incontinence Bowel |
| **Respiratory** | **Genitourinary** ☐ Incontinence Bladder |
| **Cardiovascular** ☐ AICD ☐ Pacemaker | **Musculoskeletal** |
| **Breast / Chest** | **Integumentary** |
| **Neurological** | **Significant Physical Limitations** |
| **All participants must show evidence of tuberculosis screening performed within 1 year prior to CBAS/ADHC start date:**<br>**Last PPD Test Date:**_____ ☐ **pos.** ☐ **neg. Last Chest**<br>**X-Ray Date:**_____ **Please attach results**<br>**QuantiFERON Tb test Date:**_____ ☐ **pos.** ☐ **neg.** | **Date Vitals Taken:**____/___/____<br>**Weight** _____ **Height** _____<br>**Temperature:**_____ **Blood Pressure:**___<br>**Heart Rate/Pulse:** _____ |

**Known Allergies** *(medication & environmental):*

**Section F. VITAL PARAMETERS AND ORDERS**

**PCP may adjust by entering alternative parameter range. RN will notify PCP of clinical findings.**

| | | | |
|---|---|---|---|
| **Systolic BP** Range: 90-160<br>Alternative Range: | **Diastolic BP** Range: 60-100<br>Alternative Range: | **Pulse** Range: 60-100<br>Alternative Range: | **Random Blood Glucose** Range: 70-300<br>Alternative Range: |

**Glucose Testing at Center:** ☐ N/A ☐ RBS Daily ☐ RBS Weekly ☐ RBS Monthly ☐ PRN symptoms
☐ Waive RBS readings ☐ Other (please specify):_____

**Section G. REQUEST FOR ADHC/ CBAS SERVICES (must be completed and signed by PCP)**

All patients receive the following on each day of attendance: skilled nursing, social services and/or personal care, 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 exceeding 60 minutes? ☐ None
If so, specify limitations:_____
3) Overall health prognosis?_____
4) Overall therapeutic/treatment goals:_____

## AUTHORIZATION

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 or and may require emergency room, hospitalization or institutionalization level of care. **The information provided reflects this patient's current health status. I request ADHC / CBAS services in addition to authorizing the attached standing orders.**

**PRINT PCP NAME:** _____ **NPI #:** _____

**PCP SIGNATURE** _____ **DATE**_____

**TEL:** _____ **FAX:** _____ **EMAIL:** _____

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**Patient Name:**_____ **DOB:** _____

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

**PCP STANDING ORDERS: Strike out any standing order that is not authorized.**

**Anaphylaxis Management**: Epinephrine 1:1000 0.3ml injection prn; severe anaphylaxis q 10-20 min. up to three doses per protocol

**Chest Pain/MI:** Non-enteric coated ASA 81 mg 2 tabs PO 1x

**Diarrhea:** Loperamide 2 mg PO as per package directions prn diarrhea

**Emergency O2:** At 2 - 4 lpm via nasal cannula prn, for shortness of breath; Emergency O2 to maintain O2 Sat ≥ 88%

**Fever:** (Most often with headache &/or body pain and other symptoms, please choose one for body temp > 100F)

- ☐ Acetaminophen 500 mg 2 tabs PO
- ☐ Ibuprofen 200 mg 1 tab PO taken with food

**Hypoglycemia:** RBS < 70

- ☐ Soluble glucose tablets 15 g SL & re-check RBS after 15 minutes
- ☐ Orange juice + 2 tbsp regular sugar & re-check RBS after 15 minutes
- ☐ Glucagon 1mg injection 1x PRN & re-check RBS after 15 minutes

**Indigestion:** OTC**:** Antacid: Mag – Al Plus XS unit dose per package instructions

**Influenza Vaccination:** Annual influenza virus vaccine injection per CDC recommendations

**Pain: (please choose one**)

☐ Acetaminophen

- ☐ 325 mg 1 tab PO q 4 hrs for mild pain or 2 tabs PO q 4 hrs for moderate – severe pain
- ☐ 500 mg 1 tab PO q 4 hrs for mild pain or 2 tabs PO q 4 hrs for moderate – severe pain

☐ Ibuprofen taken w/food - 200 mg 1 tab PO q 4 hrs for mild pain or 2 tabs PO q 4 hrs for moderate – severe pain

**Non-drug pain management:** Warm compress to alleviate muscle tissue discomfort. Cold compress for chronic inflammatory conditions or contusions

**Skin Care:** Clean incontinent client using pH balanced surfactant followed by drying the skin and apply A&D ointment preventatively. If there is Stage 1 or 2 irritation noted by the CBAS/ADHC licensed nursing staff, a "one time" application of Calmoseptine® ointment (or generic equivalent) will be applied and a nursing assessment conducted followed by treatment order request from the physician.

**TB Test:** Tuberculin PPD 0.1 mg ID in forearm. Read 48-72 hrs (if no screen within last 12 mo's)

**Wound care**: Minor wound protocol, including skin tears and abrasions - Cleanse with normal saline, apply antibiotic ointment, cover with dry dressing as needed

PCP Signature authorizing Standing Orders: ._____

Date: _____