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

Center Name: MountainView Adult Day Health Care Center Center Tel: 818-999-9234 Center Fax: 818-716-8030

Address: 23751 Roscoe Blvd., West Hills, CA 91304

Patient Name: _____ M ☐ F ☐ DOB: __/__/__ Last Exam Date __/__/__

DIAGNOSES / CONDITIONS (Complete or attach electronic health record (EHR))

PRIMARY DIAGNOSIS (REQUIRED):

Neuro / Cognitive
- ☐ Alzheimer's disease
- ☐ CVA
- ☐ Developmentally Disabled
- ☐ Parkinson's
- ☐ Other:
- ☐ Cognitive Impairment
- ☐ Dementia
- ☐ Neuropathy
- ☐ Seizures

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

Endocrine / Metabolic
- *Diabetes Mellitus:* ☐ (Type 1) ☐ (Type 2)
- ☐ Hyperlipidemia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Neuropathy
- ☐ Nephropathy
- ☐ 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
- ☐ Agitation
- ☐ Bipolar
- ☐ Depression
- ☐ PTSD
- ☐ 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 mos, PCP authorizes Center to place PPD.
☐ **If checked, Center requests PCP to complete PPD and record results.**

Allergies *(Medication & Environment)*: **Can Self-administer meds?** ☐ Yes ☐ No

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.			

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MEDICAL REQUEST FOR ADHC / CBAS

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 mo's) ☐ 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 1 tab PO Q4 hrs prn mild pain or 2 tabs PO Q4 hrs prn moderate - severe pain
Acetaminophen 500 mg 1 tab PO Q4 hrs prn mild pain or 2 tabs PO Q4 hrs prn moderate - severe pain
Annual influenza virus vaccine injection per CDC recommendations *(if offered at ADHC/CBAS center)*
OTC Antacid Name: per package instructions for indigestion
Emergency O2 at 2 or 4 L/min. nasal cannula prn
Ibuprofen 200 mg 1 tab PO Q4 hrs prn mild pain w/ food or 2 tabs PO Q4 hrs 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 hrs *(if no screen within last 12 mo's 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 ☐ Low NA ☐ Low Cholesterol ☐ Low Fat ☐ Ada ☐ 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:

Note: *Monitor RBS/FBS qd while Pt. is at the Center unless otherwise ordered*

Alternative orders:

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: _____ Date: _____

Signature: _____

PCP Tel: _____ PCP Fax: _____ PCP Email: _____

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Ver. 1.1 01/01/13