

CARE CONNEXUS INC.
Adult Day Services Center of Riverside

PARTICIPANT HEALTH ASSESSMENT
 (Must be filled out by physician)

Name: _____ Date: _____

Address: _____ Phone: _____

DOB: _____ Sex: _____ Age: _____ Date last seen by M.D.: _____

DIAGNOSIS: *List all Dx – Include Mental Status/Psyc Dx.*

Primary: _____ Secondary Dx's: _____

Tuberculosis Examination: PPD Mantoux Chest X-Ray

Results: Positive Negative Date Read: _____ *(Must be current/within the last 12 months)*

Any Contagious Diseases? No Yes (if yes explain) _____

Allergies: _____

In your opinion, does this person require a skilled nursing facility? Yes No (Not able to come to Day Health if SNF level of care)

SIGNIFICANT MEDICAL HISTORY AND EXAMINATION:

(Copy of a current History, Physical and Discharge Summaries may be attached.)

General: _____

Height: _____ Weight: _____

Lymphatic: _____ Cardiac: _____

HEENT: _____ Abdomen: _____

Mouth: _____ Genital: _____

Thorax: _____ Rectal: _____

Breast: _____ Muscularskeletal: _____

Lungs: _____ Neuro: _____

PROGNOSIS:

MEDICATIONS:

Physician's Orders: I authorize licensed nursing staff to administer the following medications/procedures while the client is at the ADSCR-ADHC program.

MEDICATION/TREATMENT	ROUTE	DOSE/APPLICATION	FREQUENCY

Participant Name: _____

Date: _____

DIETS AVAILABLE: Regular No Added Salt (NAS) General Diabetic Diet Pt needs blended

CURRENT FUNCTIONAL CONSIDERATIONS:

1. Ambulation Status & Physical Limitations: _____

2. Restrictions & Precautions: _____

TRANSPORTATION:

Special Van transportation may be available for your patient, but there may times when your patient may be on the van more than one (1) hour, but no more than two (2) hours.

I do **NOT** authorize the above named client to participate in the ADHC's transportation services.

I APPROVE:

Treatment per Occupational Therapist's Evaluation

Treatment per Physical Therapist's Evaluation

Treatment per Speech Therapist's Evaluation

Comments/Recommendations: _____

I have no objections to _____ attending ADHC. The initial treatment plan is up to 6 months with quarterly and six (6) month evaluations as indicated.

I wish to receive progress reports. Yes No

Physician Name (Print)

Physician's Signature

Date

Address

Phone Number

Fax Number

**PLEASE RETURN THIS COMPLETED FORM AS SOON AS POSSIBLE TO:
Any form not fully completed will be returned and will delay participant assessment and enrollment.
Adult Day Services Center of Riverside
4130 Adams St., Suite B
Riverside, CA 92504
Attn: Social Worker
(951) 509-2500**