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

Center Name:_____ Center Tel: _____ Center Fax: _____

Address: _____

Patient Name: _____ M ☐ F ☐ DOB: ___/___/19__ 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 ☐ Cognitive Impairment
☐ CVA ☐ Dementia
☐ Developmentally Disabled ☐ 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 ☐ Hyperthyroidism
☐ Hypothyroidism ☐ 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<br>☐ Incontinence Bowel |
| Respiratory | Genitourinary<br>☐ Incontinence Bladder |
| Cardiovascular<br>☐ 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):*

## 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. | | | |

## 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 ☐ No added salt ☐ No Concentrated Sweets<br>☐ 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:<br>☐ Regular ☐ Chopped ☐ Puréed ☐ Thickened Liquids<br>☐ Other: _____ |
| Pulse: 50 - 110 | Any known food restrictions? ☐ Yes ☐ No |
| Random Blood Glucose: 60 - 300 | Specify: |

**Note:** NIDDM RBS monthly/IDDM RBS weekly/prn symptoms *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: _____

Signature: _____ Date: _____

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