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

Center Name: LIHA Adult Day Health Care Center Center Tel: 279-688-0006 Center Fax: 279-688-0009

Address: 10086 Mills Station Rd. Rancho Cordova, CA 95827

Patient Name: _____ **M ☐ F ☐** **DOB:**

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

PRIMARY DIAGNOSIS (REQUIRED):

Neuro / Cognitive
☐ Aizheimer'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
☐ GERO ☐ Hemorrhoids ☐ PUD ☐ BPH ☐ UTI
☐ Other:

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

Other Condition!:i
☐ 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):* ***Last exam date***

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 ☐ N
7. Can the PTP self administrate medication? ☐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 pm mild pain or 2 tabs PO Q4 hrs pm moderate - severe pain
Acetaminophen 500 mg 1 tab PO Q4 hrs pm mild pain or 2 tabs PO Q4 hrs pm moderate - severe pain
Annual influenza virus vaccine injection per CDC recommendations *(if offered at ADHCICBAS centery*
OTC Antacid Name: Tums750 mg per package instructions for indigestion
Emergency 02 at 2 or 4 Umin. nasal cannula pm
Ibuprofen 200 mg 1 tab PO 04 hrs pm mild pain w/ food or 2 tabs PO Q4 hrs pm moderate-severepain w/ food
Loperamide 2 mg PO as per package directions pm diarrhea
Minor wound protocol: cleanse w/ normal saline; apply antibiotic ointment;cover with dry dressing pm
Non-enteric coated ASA 81 mg per MI protocol PO 1X
Tuberculin PfID 0.1 mg ID in forearm Read 48-72 hrs *(if no screen wfthin last 12 ma'sand if test offered at ADHCICBAS centery*
Do Not Resuscitate Order on File: D Yes ☐No
Addijional 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 ☐Other: _____ __ Center may deviate from No Concentrated Sweets diet order up to two times a month (special occasions)
Systolic Blood Pressure: 80 - 170	**DIET TEXTURE:**
Diastolic Blood Pressure: 50 - **11**0	☐ Regular ☐ Chopped ☐ Pureed ☐ Thickened Liquids
Pulse: 50 - 110	☐Other: _____
Random Blood Glucose: 60 - 300	Any known food restrictions? ☐ Yes ☐No Specify:

Note: NIDDM RBS monthly/IDDM RBS weekly/pm 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: _____

Release of Medical Information

LIHA ADHC Center
10086 Mills Station Rd.
Rancho Cordova, CA 95827
Phone – 279-688-0006
Fax - 279-688-0009

Date:_____

To:_____

_____

Name of Participant:_____DOB:_____

SSN:_____Insurance #_____

I, _____, grant my permission to _____

_____ To release medical records/information concerning me to their insurer or other agencies or individuals who may provide medical or social services to me.

Additionally, I authorize release of medical information to _____ This information shall include but not be limited to:

( ) Medical History/Physical.
( ) Test Results (_____)
( ) TB-PPD/Chest X-Ray Results.
( ) Immunization Records.
( ) Medication Records
( ) Other (_____)

Date(s) of Hospitalization:_____

Place of Last Hospitalization:_____

Signature of Participant/Assigned Agent:_____Date:_____

Signature of Witness:_____Date:_____

Authorization valid for 180 days