

**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):\***

<b>Neuro / Cognitive</b> <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> CVA <input type="checkbox"/> Dementia <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's <input type="checkbox"/> Seizures <input type="checkbox"/> Other:	<b>Cardiovascular</b> <input type="checkbox"/> Arrhythmia <input type="checkbox"/> A-fib <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> CAD <input type="checkbox"/> CABG <input type="checkbox"/> CHF <input type="checkbox"/> HTN <input type="checkbox"/> MI <input type="checkbox"/> PVD <input type="checkbox"/> Other:
<b>Endocrine / Metabolic</b> <i>Diabetes Mellitus:</i> <input type="checkbox"/> (Type 1) <input type="checkbox"/> (Type 2) <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Neuropathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other:	<b>Musculoskeletal</b> <input type="checkbox"/> Chronic Back Pain <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Gout <input type="checkbox"/> Other:
<b>Pulmonary / Respiratory</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Other:	<b>Gastrointestinal / Genitourinary</b> <input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> GERD <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> PUD <input type="checkbox"/> BPH <input type="checkbox"/> UTI <input type="checkbox"/> Other:
<b>Behavioral Health</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Agitation <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression <input type="checkbox"/> PTSD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: Name of other treating MD, if known: _____	<b>Other Conditions</b> <input type="checkbox"/> Cataracts <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Insomnia <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Low Vision <input type="checkbox"/> Skin Breakdown <input type="checkbox"/> Aphasia <input type="checkbox"/> Ataxia <input type="checkbox"/> Other:

**PHYSICAL EXAMINATION (Complete or Attach EHR)**

Comments	Comments
HEENT	Gastrointestinal <input type="checkbox"/> Incontinence Bowel
Respiratory	Genitourinary <input type="checkbox"/> Incontinence Bladder
Cardiovascular <input type="checkbox"/> AICD <input type="checkbox"/> 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?              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Recent hospitalization? (w/in 6 mo's)       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Any known history of falls? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Any significant medical history?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Medication non-compliance?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Any known evidence of communicable disease? | <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional or Alternative Orders: _____

VITAL PARAMETERS	DIET ORDERS
<b>MD may adjust by striking thru and entering desired parameter(s) for notification.</b>	<input type="checkbox"/> Regular <input type="checkbox"/> No added salt <input type="checkbox"/> No Concentrated Sweets <input type="checkbox"/> 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	<b>DIET TEXTURE:</b>
Pulse: 50 - 110	<input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Puréed <input type="checkbox"/> Thickened Liquids
Random Blood Glucose: 60 - 300	<input type="checkbox"/> Other: _____
	Any known food restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Specify: _____
<b>Note: NIDDM RBS monthly/IDDM RBS weekly/prn symptoms unless otherwise ordered.</b>	
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: \_\_\_\_\_