AltaMedix
Adult Day Health Care
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HISTORY AND PHYSICAL FOR ADULT DAY HEALTH CARE / COMMUNITY BASED ADULT SERVICES

Patient Name:		DOB:
Phone Number:		
Address:	City:	Zip:

DIAGNOSES/CONDITIONS (Complete or attach Electronic Health Record)

Primary Diagnosis (Required):

Neuro / Cognitive
☐ Alzheimer's Disease ☐ Cognitive Impairment
☐ CVA ☐ Dementia
☐ Developmentally Disabled ☐ Neuropathy
☐ Parkinson's Disease ☐ 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
☐ Retinopathy ☐ Nephropathy
☐ 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 Electronic Health Record)

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:

Assistive Devices: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Vision/Hearing Aid ☐ Other: _____

TB SCREENING (required by law within last 12 months)

PPD Date read: _____ Result: ☐ Positive ☐ Negative Chest X-ray Date: _____ Result: ☐ Positive ☐ Negative

1 Unsteady Gait?	☐ Yes	☐ No	4 Recent hospitalization? (within 6 months)	☐ Yes	☐ No
2 Any known history of falls?	☐ Yes	☐ No	5 Any significant medical history?	☐ Yes	☐ No
3 Medication non-compliance?	☐ Yes	☐ No	6 Any known evidence of communicable disease>	☐ Yes	☐ No

Please describe any "Yes":

MEDICAL REQUEST FOR ADULT DAY HEALTH CARE / COMMUNITY BASED ADULT SERVICES

Patient's Name:

MEDICATION PROFILE (Complete or attach Electronic Health Record)

Medication	Dosage	Route	Freq	Medication	Dosage	Route	Freq
1				6			
2				7			
3				8			
4				9			
5				10			

Allergies (Medication & Environment):

STANDING ORDERS (Please strike through any orders not approved and write in alternative orders)

Acetaminophen 325 mg 1 tab PO Q4 hours prn mild pain or 2 tabs PO Q4 hours prn moderate - severe pain

Acetaminophen 500 mg1 tab PO Q4 hours prn mild pain or 2 tabs PO Q4 hours 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 hours prn mild pain w/ food or 2 tabs PO Q4 hours prn moderate-severe pain w/ food

Loperamide (Imodium) 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 hours *(if no screen within last 12 months and if test offered at ADHC/CBAS center)*

Do Not Resuscitate Order on File: ☐ Yes ☐ No

VITAL PARAMETERS

MD may adjust by striking thru and entering specific parameters for notification

Systolic Blood Pressure:	**80 - 170**	Each day of attendance
Diastolic Blood Pressure:	**50 - 110**	Each day of attendance
Pulse:	**50 - 110**	Each day of attendance
Random Blood Glucose:	**60 - 300**	Each day of attendance

DIET ORDERS

☐ Regular ☐ No Added Salt ☐ No Concentrated Sugar

☐ Other: _____

Center may deviate from No Concentrated Sugar diet order up to two times a month (special occasions)

DIET TEXTURE:

☐ Regular ☐ Texture ☐ Chopped ☐ Pureed ☐ Thickened Liquids

☐ Other: _____

Alternative orders:

REQUEST FOR ADULT DAY HEALTH CARE/COMMUNITY BASED ADULT SERVICES (MUST BE COMPLETED AND SIGNED BY PCP):

All patients receive the following on each day of attendance: **skilled nursing, social services, 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) Are there any medical contraindications for receiving any of the above additional services? ☐ None
   If so, please 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. By signing below, I certify that the Adult Day Health Care / Community Based Adult services are medically necessary.**

PCP Name: Signature: Date:

PCP Address:

PCP Phone: PCP Fax: