CARSON ADULT DAY HEALTH CARE CENTER

23517 S. Main Street, Suite 110, Carson, CA 90745
Phone: (310) 522 – 3860 Fax: (310) 522 - 3866

PARTICIPANT'S HISTORY AND PHYSICAL RECORD		
Name:	Age:	DOB:
[ ] Male [ ] Female		
Current Medical Exam		
General:	Lungs:	
H.E.E.N.T.:	Heart:	
Mouth:	Abdomen:	
Thorax:	Genitourinary:	
Breast:	Musculoskeletal:	
Lymphatic:	Rectal:	
Vitals		
Weight:	Height:	
Temperature:	Blood Pressure:	
Heart Rate: (R) (AP)	History of Seizures? [ ] Yes [ ] No	
Current Medical Status		
	ICD10 Code	List any current health issue:
Diagnosis:		
Primary:		
Secondary:		
Prognosis:		
Any indication of communicable disease? [ ] Yes [ ] No		
Last PPD Test: **Result:**	**Last Chest X-Ray:** **Result:**	
I approved an order for the ADHC Licensed Nurse to administer the PPD test: [ ] Yes [ ] No		
Significant Medical History		
Diet and Nutrition		
[ ] Regular [ ] Low Salt [ ] Low fat / Low Cholesterol [ ] Diabetic [ ] Other:		
Center may deviate from regular diet up to 2x per month on special occasions: [ ] Yes [ ] No		
Does your patient require Nutritional Assessment? [ ] Yes [ ] No		
Ambulation		
[ ] Ambulatory	[ ] Ambulates with assistance	[ ] Non Ambulatory
[ ] No Device	[ ] Cane [ ] Walker	[ ] Wheelchair

Current Medications			
Medications:	**Dose:**	**Frequency:**	**Indication:**

Allergies:

Physician's Standing Orders (Please Check Yes or No)	**Comments**
Is this patient capable of self-administration of medications? [ ] Yes [ ] No	
Center's Licensed nurse(s) may administer prescribed medication: [ ] Yes [ ] No	
Acetaminophen (500 mg), 2 tablets, PO, q4 hours, PRN Pain: [ ] Yes [ ] No	
Antacid, 30 ml. PO, q4 hours, PRN Stomach upset: [ ] Yes [ ] No	
Pepto Bismol, 30ml., PO, q30-60 minutes, PRN Diarrhea: [ ] Yes [ ] No	
PPD or CX-Ray (If PPD positive) for TB clearance [ ] Yes [ ] No	
02 @ 2 L/min. PRN for SOB: [ ] Yes [ ] No	
First Aide PRN for Emergency Protocol: [ ] Yes [ ] No	
CPR PRN for Emergency Protocol: [ ] Yes [ ] No	

Normal transmit time is 1 hour or less. Occasionally, transportation may take longer, 1-1 ½ hours. Are there any contraindications to ride longer than 1 hour? (if none, you approve participant can be transported more than 1 hour) [ ] Yes [ ] No

For Diabetic Patients: Licensed nurse may test participant's Blood Sugar (fingerstick) daily and/or as needed while at center [ ] Approved [ ] Other: _____ Blood Sugar test results/ranges which you wish to be notified: Min: _____mg/dl Max: _____mg/dl	***For Hypo/Hypertensive Patients:*** Licensed nurse may take Blood Pressure daily and/or as needed while at center [ ] Approved [ ] Other: _____ Blood Pressure result/ranges which you wish to be notified: Min: _____mmHg Max: _____mmHg

Therapy

As part of the assessment process, the Physical Therapist and Occupational Therapist routinely evaluate all participants. Please indicate if your patient requires evaluation by the Speech Therapist as well.

[ ] Physical Therapy [ ] Occupational Therapy [ ] Speech Therapy

Psychological / Psychiatric Services

Does your patient require a Psychiatric or Psychological evaluation? [ ] Yes [ ] No

Physician's Approval

I approved of my patient attending Adult Day Health Care Center: [ ] Yes [ ] No

Physician's Signature:	Date:
Printed Name:	Specialty:
Address:	Phone:
	Fax: