Ventura County Adult Day Health Care Center
1700 N. Lombard St., #150, Oxnard, CA 93030
Office#: (805) 278-4321 Fax#: (805) 278-4322

PHYSICIAN'S HEALTH ASSESSMENT/MEDICAL INFORMATION AND AUTHORIZATION FOR TREATMENT

Patient Name:		**DOB:**	
☐ **Male** ☐ **Female**		**Telephone#:**	
Current Medical Exam & Status			
Diagnoses	**ICD9 Code**	**General:**	**Lungs:**
Primary:		**H.E.E.N.T.:**	**Heart:**
Secondary:		**Mouth:**	**Pacemaker:**
		Thorax:	**Abdomen:**
		Breast:	**Genitourinary:**
		Lymphatic:	**Musculoskeletal:**
		Other:	**Rectal:**

Vitals			
Weight:	**Height:**	**Temperature:**	**Blood Pressure:**
Heart Rate:	**Resp:**	**History of Seizure** ☐ **Yes**	☐ **No**
Any indication of communicable disease? No ( ) Yes ( ) If Yes:			
Last PPD test:	**Last chest x-ray:**	**Results:**	
Significant Medical History:			
Infectious Disease: No ( ) Yes ( ) If Yes, please explain:			
Physical Disabilities: No ( ) Yes ( ) If Yes, please explain:			
Diet and Nutrition			
☐ **Regular** ☐ **Regular diet with no added salt** ☐ **Weight Control**			
☐ **Regular diet with no concentrated sweets (Diabetic Diet)** ☐ **Other** _____			
☐ **Low Cholesterol** ☐ **Mechanical Soft** ☐ **Puree** ☐ **Fluid Restriction**			
Ambulation			
☐ **Ambulatory**	☐ **Non-Ambulatory**	☐ **Ambulates with Assistance**	
☐ **No Devices**	☐ **Cane**	☐ **Quad Cane**	☐ **Walker** ☐ **Wheelchair**

Therapy

As part of the assessment process, the Physical Therapist and Occupational Therapist routinely evaluate all participants. Speech Therapist evaluates when indicated by Nursing Assessment.

******(Massage Chair Therapy: Patient is medically capable of receiving vibrating massage with low heat. Please check if patient is not capable ☐)******

Psychological/Psychiatric Services

Psychological Assessment will be completed by the LCSW based on diagnosis, medication and/or behavior.

Transportation

Normal transit time is one hour or less. Occasionally, transportation may take longer, but not exceed one and one-half hours. Are there any contraindications to a ride longer than one hour? ☐ Yes ☐ No

If yes, please explain:

Patient Name: **Date of Birth:**

Current Medications (For More Medications, Please Attach Separate Sheet)			
Medication:	**Dose:**	**Frequency:**	**Indication:**

Allergies:

Is this patient capable of self-administration of medications? ☐ **Yes** ☐ **No**

OTC Medications

For mild pain, stomach upset, intestinal distress, or oxygen needs, my patient may be given the following at the frequency indicated: **(Generic brands may be substituted)**

Pain	Stomach Upset/Intestinal Distress
☐ Aspirin (325 mg.), 2 tablets, q 6 hours prn	☐ Maalox, 30 cc, q 4 hours prn (may substitute Mylanta)
☐ Ibuprofen (200 mg.), 1 tablet, q 4 hours prn ☐ Ibuprofen (200 mg.), 2 tablets, q 4 hours prn	☐ Kaopectate, 2 Tbs., prn diarrhea, NTE 6 doses/24 hours
☐ Acetaminophen (500 mg.), 2 tablets, q 4 hours prn	☐ Laxative (M.O.M.), 30 cc qd, prn constipation
☐ Neosporin Ointment for skin abrasion/cuts prn	☐ PeptoBismol 30 ml., q 30-60 minutes, prn diarrhea, NTE 8 doses/24 hr
☐ O2 2-3 L/min. PRN dyspnea	☐ Other:

Special Orders

All participants attending Adult Day Health Care Center are monitored by Licensed Nurses who will notify you of any significant changes.

If participant's diagnoses include diabetes, I approve an order for the ADHC Licensed Nurse to administer glucose monitoring test: ☐ **Yes** ☐ **No**

Blood Sugar Test Frequency:
☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **AC Breakfast** ☐ **AC Lunch**
☐ **Blood Sugar:** ↓ _____ **and** ↑ _____
(Without Given Parameters BS notification will default 70 to 250 mg/DL)
☐ **6 oz. Apple or Orange Juice with 2 packets of sugar**
☐ **1 Tube Insta Glucose and repeat as needed**
(Recheck B.S. q 15-30 mins. Until 70mg/DL or more

Blood Pressure Test Frequency:
☐ **Daily** ☐ **Weekly** ☐ **Monthly**
Parameters by which M.D. wishes to be notified:
☐ **Blood Pressure:** ↓ _____ **and** ↑ _____
(Without Given Parameters BP notification will default to 180/100 or 90/60)

Physician Approval

I approve TB-PPD Testing/Chest X-Ray for this patient, for clearance purposes. ☐ **Yes** ☐ **No**
I approve of my patient's attending Adult Day Health Care for the next 180 days. ☐ **Yes** ☐ **No**

Patient has a high potential for deterioration without ADHC services, which may result in ER visits, SNF, Acute Hospitalization, or Inpatient Mental Services.

Physician's Signature:	**Date:**
Printed Name:	**Specialty:**
Address:	
Phone #:	**FAX #:**