301 East J St, Chula Vista, CA 91910
Phone: (619) 420-1404 ● Fax: (619) 420-1408

GENERAL INFORMATION

NAME:			PHONE:	
ADDRESS:			[ ] Home [ ] ILF [ ] B&C [ ] Other	
DOB:	GENDER:	ETHNICITY:	PRIMARY LANGUAGE:	
SOURCE OF INCOME:	SSN:	IHSS Hrs/Mo.	MARITAL STATUS: [ ] S [ ] M [ ] W [ ] D [ ] SEP	

REFERRAL INFORMATION

REFERRED BY : Self, Family, Managed Care Plan, Discharge Planner, Conservator, Case Manager, etc. How did you hear about us?
REFERRAL REASON: What brings you to Open Arms? What are your goals? What would you like to get out of the program?

INSURANCE INFORMATION

MEDI-CAL #: ISSUE DATE:	MANAGED CARE PLAN:
MEDICARE #:	PT ID#

MEDICAL CONTACTS

PRIMARY CARE PHYSICIAN:		PSYCHIATRIST:	
ADDRESS:		ADDRESS:	
PHONE:	FAX:	PHONE:	FAX:

EMERGENCY CONTACTS

NAME:	PHONE:	NAME:	PHONE:
RELATIONSHIP:		RELATIONSHIP:	

NAME:	PHONE:	NAME:	PHONE:
RELATIONSHIP:		RELATIONSHIP:	

HISTORY AND PHYSICAL for Adult Day Health Care

Center Name: Open Arms ADHC
Address: 301 East J St, Chula Vista, CA 91910
Center Phone: (619) 420-1404
Center Fax: (619) 420-1408
Patient Name: _____
M [ ] **F** [ ] **DOB:**___/___/____ **Exam Date:**___/___/____

DIAGNOSIS/CONDITIONS (Complete or attach electronic health record (EHR)

Neuro / Cognitive
[ ] Alzheimer'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)
[ ] Hyperthyroidism
[ ] Hyperlipidemia [ ] Neuropathy [ ] Nephropathy
[ ] Hypothyroidism
[ ] Retinopathy
[ ] Other:

Musculoskeletal
[ ] Chronic Back Pain [ ] Joint Replacement
[ ] Osteoarthritis [ ] Osteoporosis
[ ] Spinal Stenosis
[ ] 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 [ ] Bipolar [ ] Depression
[ ] Schizophrenia [ ] Agitation
[ ] Schizoaffective Disorder
[ ] Other:

Other Conditions
[ ] Cataracts [ ] Difficulty Swallowing [ ] Insomnia
[ ] Glaucoma [ ] Hearing Loss [ ] Low Vision
[ ] Skin Breakdown
[ ] 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 & Hypersensitivities:

MEDICATION PROFILE (Please attach Medication List)

Self-Administration of medication while at ADHC:

[ ] Participant CAN Self-Administer own medication(s) while at ADHC.

[ ] Participant CANNOT Self-Administer own medication(s) while at ADHC.

MEDICAL REQUEST FOR ADULT DAY HEALTH CARE / CBAS

Patient Name:

1. Unsteady Gait	[ ] Yes [ ] No	3. Any Significant medical history?	[ ] Yes [ ] No
2. Any known history of falls?	[ ] Yes [ ] No	4. Any know evidence of communicable disease?	[ ] 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 650 mg 1 tab PO Q4 hrs prn pain or temperature > 101°F.

A&D ointment topical PRN for dry skin; Barrier cream topical PRN for incontinence, skin redness.

Benadryl 25mg 1 tab PO Q4 hrs prn for allergies.

Emergency O_2 at 2 or 4 L/min, nasal cannula prn.

Equate Antacid (Regular Strength) per package instructions for indigestion.

Loperamide 15 mL after the first loose stool; 7.5 mL after each subsequent stool; but no more than 30 mL in 24 hrs or as per package directions prn diarrhea.

Minor wound protocol: cleanse w/ normal saline; pat dry; apply antibiotic ointment; cover with dry dressing prn.

Nitrostat 0.4 mg SL Q 5 mins x3 doses for chest pain. May send to ER via 911 if unrelieved.

Tuberculin PPD 0.1 mg ID in forearm r/o TB. Read 48-72 hrs (if no screen within last 12 mo's).

Tussin 10 mL Q 4hrs PO PRN for cough.

Additional or Alternative Orders:

VITAL PARAMETERS

MD may adjust by striking thru and entering desired parameter(s) for notification.

Systolic Blood Pressure:	80 - 170
Diastolic Blood Pressure:	50 - 110
Pulse:	50 - 110
Random Blood Glucose:	60 - 300

DIET ORDERS

[ ] Regular [ ] No added salt [ ] Low Concentrated Sweets
[ ] Other: _____
Center may deviate from low concentrated sweets diet order up to two times a month (special occasions)

DIET TEXTURE:
[ ] Regular [ ] Chopped [ ] Puréed [ ] Thickened Liquids
[ ] Other: _____
Any known food restrictions? [ ] Yes [ ] No
Specify: _____

Note: NIDDM RBS monthly/IDD RBS weekly/prn 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) Contraindications for receiving any of the above additional services: [ ] None [ ] Yes, please specify:

(2) Contraindications for transportation, one way, more than 60 mins: [ ] None [ ] Yes, please specify:

(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 authorization the standing orders.

Print PCP Name:

PCP Signature:	Date:

PCP Tel:	PCP Fax:	PCP Email: