301 East J St, Chula Vista, CA 91910

Phone: (619) 420-1404 • Fax: (619) 420-1408

FAX

TO: _____ FROM: _____

FAX: _____ PAGES: _____

PHONE: _____ DATE: _____

RE: _____ DOB: _____

☐ Urgent ☐ For Review ☐ Please comment ☐ Please reply ☐ Recycle

Dear Dr. _____,

The above participant wishes to enroll with Open Arms ADHC/CBAS and requires the following so that he/she may enroll:

1. Completed Health Assessment
2. History & Physical Report including list of all current medications.
3. Negative PPD/negative CXR within one year or order for PPD administration

Note: *Please include a copy of the COVID-19 Vaccination Card*

Thank you for your time in reviewing this matter. If you have any questions or comments, feel free to contact the center at (619) 420-1404. Thank you.

Sincerely,

_____

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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:	

SUPPORTTVEDOCUMENTS/SERVICES

☐ DNR ORDER ☐ ADVANCED DIRECTIVE ☐ DPOA ACTIVE ☐ DPOA HEALTH CARE
☐ DPOA FINANCIAL ☐ POLST

PATIENT HISTORY AND PHYSICAL FOR ADULT DAY HEALTH CARE / COMMUNITY BASED ADULT SERVICES

Patient Name: _____ **M ☐ F ☐ DOB:** ___/___/____ **Last Exam Date** ___/___/____

Center Name: Open Arms ADHC Center Tel: (619) 420-1404 Center Fax: (619) 420-1408

Address: 301 East J St Chula Vista CA 91910-6223

☐ **EHR attached (If EHR is attached, bypass any related sections below)**

Section A. DIAGNOSES / CONDITIONS reflecting the patient's health status

***PRIMARY DIAGNOSIS (REQUIRED):** _____ *** Include ICD-10 Code. Check all that apply below.**

SECONDARY DIAGNOSIS: _____

Central Nervous System Diseases (G00-G99)

☐ Parkinson's disease ☐ Cerebral palsy
☐ Alzheimer's disease ☐ Seizure disorder
☐ TIAs & related syndrome ☐ Cerebrovascular disease
☐ Idiopathic neuropathy ☐ Hydrocephalus
☐ Hemiplegia/hemiparesis

☐ Other nervous system (specify): _____

Diseases of the Circulatory System (I00-I99)

☐ Hypertension ☐ A-fib ☐ MI ☐ Angina
☐ Arrhythmia ☐ PVD ☐ CHF
☐ Pulmonary heart disease ☐ Atherosclerosis

☐ Other circulatory (specify): _____

Endocrine, Nutritional & Metabolic Diseases (E00-E89)

☐ Diabetes Mellitus
☐ (Type 1) ☐ (Type 2) with complications:
☐ Retinopathy ☐ Neuropathy ☐ Nephropathy
☐ Other _____

☐ Hyperlipidemia ☐ Hyperthyroidism
☐ Hypothyroidism ☐ Nutritional Deficiency

☐ Other Metabolic Disorder (specify): _____

Diseases of Musculoskeletal/Connective Tissues (M00-M99)

☐ Rheumatoid Arthritis ☐ Osteoarthritis
☐ Gout ☐ Osteoporosis

☐ Joint replacement _____

☐ Other musculoskeletal disorder (specify): _____

☐ Other connective tissue disorder (specify): _____

Pulmonary / Respiratory Diseases (J00-J99)

☐ Asthma ☐ Chronic Bronchitis
☐ COPD ☐ Emphysema

☐ Other respiratory/pulmonary diseases (specify): _____

Diseases of Digestive (K00-K95) & Genitourinary (N00-N99) Systems

☐ Chronic Liver Disease ☐ BPH
☐ Hemorrhoids ☐ GERD
☐ Liver disease ☐ Peptic Ulcer
☐ Chronic UTI
☐ Chronic Kidney Disease Stage _____

☐ Other digestive & genitourinary (specify): _____

Mental, Behavioral & Neurodevelopmental Disorders (F01-F99)

☐ Anxiety ☐ Bipolar ☐ Depression
☐ Developmental delay w/ behavioral symptoms
☐ Schizophrenia ☐ Agitation
☐ Unspecified dementia (pre-senile, senile, primary degenerative)

☐ Other behavioral & emotional disorder (specify): _____

Other Conditions

☐ Cataracts ☐ Macular degeneration ☐ Insomnia
☐ Glaucoma ☐ Hearing loss ☐ Low vision/blind
☐ Skin breakdown ☐ Ataxia ☐ Aphasia

☐ Other conditions (specify): _____

Patient Name: _____ DOB: ___/___/_____

Section B. CURRENT MEDICATIONS (If EHR is attached, bypass Medication Section below)
(Center will conduct medication reconciliation and report inconsistent findings to MD)

Medication	Dosage	Route	Freq	Medication	Dosage	Route	Freq
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

Section C. PHYSICAL EXAMINATION

Comments	Comments
HEENT	**Gastrointestinal** ☐ Incontinence Bowel
Respiratory	**Genitourinary** ☐ Incontinence Bladder
Cardiovascular ☐ AICD ☐ Pacemaker	**Musculoskeletal**
Breast / Chest	**Integumentary**
Neurological	**Significant Physical Limitations**
All participants must show evidence of tuberculosis screening performed within 1 year prior to CBAS/ADHC start date: **Last PPD Test Date:**_____ ☐**pos.** ☐**neg.** **Last Chest X-Ray Date:**_____ **Please attach results** **QuantiFERON Tb test Date:** _____ ☐**pos.** ☐**neg.**	**Date Vitals Taken:** ___/___/____ **Weight:**_____ **Height:**_____ **Temperature:**_____ **Blood Pressure:**_____ **Heart Rate/Pulse:**_____
Known Allergies *(medication & environmental):*	

Section D. VITAL PARAMETERS AND ORDERS

PCP may adjust by entering alternative parameter range. RN will notify PCP of clinical findings.

Systolic BP	Diastolic BP	Pulse	Random Blood Glucose
Range: 90-160	Range: 60-100	Range: 60-100	Range: 70-300
Alternative Range:	Alternative Range:	Alternative Range:	Alternative Range:

Glucose Testing at Center: ☐ N/A ☐ RBS Daily ☐ RBS Weekly ☐ RBS Monthly ☐ PRN symptoms

☐ Waive RBS readings ☐ Other (please specify):_____

Section E. DIET ORDERS

☐ Regular (no added salt or added fat) ☐ No concentrated sweets (NCS) ☐ Low fat ☐ Other (specify): _____

☐ Regular texture ☐ Chopped ☐ Mechanical soft/finely chopped texture ☐ Pureed texture

☐ Thickened Liquids: ☐ Yes ☐ No If Yes, *consistency:* ☐ Nectar-thick ☐ Honey-thick ☐ Pudding-thick

☐ NPO, G/J-Tube Feedings:_____ (formula & amount/day)

Any known food restrictions? ☐ Yes ☐ No Specify:	Any known food allergies? ☐ Yes ☐ No Specify:

Patient Name: _____ DOB: ___/___/_____

Section F. RISK FACTORS

1. Unsteady gait?	☐ Yes ☐ No	4. Recent hospitalization? (w/in 6 mo's)	☐ Yes ☐ No
2. Hx of falls?	☐ Yes ☐ No	5. Medication mismanagement?	☐ Yes ☐ No
3. Hx of communicable disease?	☐ Yes ☐ No	If No, *is patient able to self-administer at Center?*	☐ Yes ☐ No

Please describe any "Yes" answers, if details are known:_____

Section G. REQUEST FOR ADHC/CBAS SERVICES (must be completed and signed by PCP)

All patients receive the following on each day of attendance: skilled nursing, social services and/or personal care, 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 exceeding 60 minutes? ☐ None

If so, specify limitations:_____

3) Overall health prognosis?_____

4) Overall therapeutic/treatment goals:_____

AUTHORIZATION

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 or and may require emergency room, hospitalization or institutionalization level of care. **The information provided reflects this patient's current health status. I request ADHC / CBAS services in addition to authorizing the attached standing orders.**

Print PCP Name:		
PCP Signature:		Date:
Tel:	Fax:	Email: