Sultan
Adult Day Health Care Center

125 W. Cerritos Ave. ♦ Anaheim, CA 92805
714-778-9000 Tel ♦ 714-778-9010 Fax

PATIENT HISTORY AND PHYSICAL

(This form is to be filled out by a Medical Provider)

Patient Name:		**Date of Exam:**	
Sex:	**Male** ☐ **Female** ☐	**DOB:**	
Address:		**Tel #:**	
Emergency Contact:		**Tel #:**	

DIAGNOSIS/CONDITIONS reflecting the Patient's current health status or

attach electronic health record (EHR)

Neuro/Cognitive

☐ Alzheimer's Disease
☐ CVA
☐ Developmentally Disabled
☐ Parkinson's Disease
☐ Other: _____
☐ Cognitive Impairment
☐ Dementia
☐ Neuropathy
☐ Seizure

Cardiovascular

☐ Arrhythmia
☐ CHF
☐ CAD
☐ Other: _____
☐ HTN
☐ Angina
☐ PVD
☐ Anemia

Endocrine/Metabolic

Diabetes Mellitus: ☐ IDDM ☐ NIDDM
Please include most recent A1C reading: _____

☐ Hyperlipidemia
☐ Hypothyroidism
☐ Other:_____
☐ Hyperthyroidism
☐ Neuropathy
☐ Retinopathy

Musculoskeletal

☐ Chronic Back Pain
☐ Spinal Stenosis
☐ Other: _____
☐ Joint Replacement
☐ Osteoporosis
☐ Osteoarthritis

Pulmonary/Respiratory

☐ Asthma
☐ COPD
☐ Other:_____
☐ Chronic Bronchitis
☐ Emphysema

Gastrointestinal/Genitourinary

☐ Chronic Liver Disease
☐ GERD
☐ Incontinence
☐ Other:_____
☐ UTI
☐ Chronic Kidney Disease
☐ Hemorrhoids
☐ PUD

Behavioral Health

☐ Anxiety
☐ Schizophrenia
☐ Other:_____
☐ Depression
☐ Bipolar

Other Conditions

☐ Cataract
☐ Glaucoma
☐ Skin Breakdown
☐
Other:_____
☐ Difficulty Swallowing
☐ Hearing Loss
☐ Insomnia

Additional Diagnoses/Medical Conditions/Hx of Hospitalizations/ER/Surgeries/Falls in the past year:

Patient Name:	

MEDICAL REQUEST FOR ADULT DAY HEALTH CARE

PHYSICAL EXAMINATION (Complete or attach EHR)					
	WNL	COMMENTS		WNL	COMMENTS
HEENT	☐		Gastrointestinal	☐	
Respiratory	☐		Genitourinary	☐	
Cardiovascular	☐		Musculoskeletal	☐	
Breast/Chest	☐		Integumentary	☐	
Neurological	☐		Other:	☐	

MEDICATION PROFILE (Complete or attach EHR)							
Medication	Dosage	Route	Frequency	Medication	Dosage	Route	Frequency
①				⑪			
②				⑫			
③				⑬			
④				⑭			
⑤				⑮			
⑥				⑯			
⑦				⑰			
⑧				⑱			
⑨				⑲			
⑩				⑳			

Is the Patient authorized to *SELF ADMINISTER* medications (OTC/RX) at the center? ☐ Yes ☐ No

TB SCREENING as required by law (within the past 12 months)			
PPD Date:	Result:	CXR Date:	Result:

VITAL SIGNS					
Height:	Weight:	Temp:	BP:	Pulse:	Resp. Rate:

VITAL PARAMETERS

Nursing Department will notify PCP when:

Systolic Blood Pressure: < 80 or > 180mmHg Diastolic Blood Pressure: < 50 or >100 mmHg

Heart Rate: < 50 or > 110 BPM Random Blood Glucose: < 60 or > 400 mg/dl

DIET ORDER

☐ **ADHC** hot meal consists of LCS 1200 Kcal, bland with high fiber, NAS (low sodium), low saturated fat and low cholesterol. Center may deviate from low concentrated sweets diet order up to two times a month (special occasions).

☐ Other:

DIET TEXTURE

☐ Regular ☐ Chopped ☐ Pureed ☐ Thickened Liquids Other:

Any known food restrictions? ☐ Yes ☐ No

Specify:

Patient Name:	

STANDING ORDERS (STRIKE OUT ORDERS THAT ARE NOT APPLICABLE)
DIABETIC ORDER: Monitor blood sugar at center 1x/wk and PRN
CHEST PAIN: NTG 0.4 mg S/L, 1 tab Q5 min. x 3 doses
MI PROTOCOL: ASA 81 mg PO, 1 dose
SOB + SPO2 <95%: O2 @ 2 liters/min via NC x 15 min.
PAIN/ACUTE FEVER: Acetaminophen 500 mg. PO, 1 tab Q4-6H PRN for mild pain or 2 tabs Q4-6 H for moderate to severe pain
PAIN/INFLAMMATION: Ibuprofen 200 mg PO, 1 tab Q4-6H
INDIGESTION/ACID/GAS: calcium carbonate (Tums) 1000mg 1-2 chewable tabs Q 12H, Al(OH)3+Mg(OH)2+simethicone (Maalox) 10-20mL Q 6H, simethicone (Gas-X) 125mg 1-2 tabs after meals
ACUTE COUGH: guaifenesin non-drowsy 10 ml Q4H
ACUTE ALLERGY (itchy watery eyes, nose or throat) : loratidine 10mg 1 tab QD
MINOR RASH/IRRITATION/ITCHING: Hydrocortisone cream 1% topical, Calmoseptine ointment topical
CONSTIPATION: Polyethylene glycol 17 gm/24H mix with 8 oz.H2O or methylcellulose 2 tabs + 8 oz. H2O
MINOR WOUND CARE: Saline wash /spray + antibiotic ointment
**Maximum duration on PRN medications vary and will depend on specific instructions written on med label.*

REQUEST FOR ADULT DAY HEALTH CARE SERVICES SECTION
All Patients receive the following on each day of attendance:
* Skilled Nursing Service | *Social Services | *Personal Care | *Therapeutic Activities | *Meal Services
Additional services provided, as needed, include:
*Physical Therapy | *Occupational Therapy | *Speech Therapy | *Mental Health | *Transportation
Based on multidisciplinary team assessment. ADHC services are ongoing unless otherwise indicated.

1. Indicate contraindications for receiving any of the above additional services: ☐ **None**				
If any, explain:				
2. Please check if Patient is unable to travel more than one hour each way: ☐				
3. Overall health prognosis: ☐ **Good**	☐ **Fair**	☐ **Poor**	☐ **Unknown**	
4. Overall therapeutic goals:				

A high potential exists for the deterioration of the Patient's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if ADHC services are not provided.

The information provided in this document reflects this Patient's current health status in addition to authorizing standing orders.

PCP Printed Name		**Signature**		**Date**
Tel#:		**Fax#:**		**Email:**
Address:				