



Alzheimer's Family Services Center
9451 Indianapolis Avenue • Huntington Beach, CA 92646
Phone (714) 593-9630 • Fax (714) 964-5321
ATTN: Care Manager

HEALTH RECORD

Participant's Name:		Exam Date:	
Date of Birth:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
CURRENT MEDICAL EXAM			
General:		Lungs:	
Eyes:		Heart:	
Ears:		Abdomen:	
Nose:		Genitourinary:	
Mouth/Throat:		Musculoskeletal:	
Skin:		Rectal:	Lower Extremities:
VITAL SIGNS			
Wt:	Ht:	P:	T:
Blood Pressure: <input type="checkbox"/> Sitting: <input type="checkbox"/> Standing:		History of Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DIAGNOSES			
1.		4.	
2.		5.	
3.		6.	
Prognosis: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Any indication of communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>Last PPD test:</i>		<i>Last CXR:</i>	
		<i>Results:</i>	
AFSC nurse may administer TB test: <input type="checkbox"/> Yes <input type="checkbox"/> No			
SIGNIFICANT MEDICAL HISTORY			
ALLERGIES:			
DIET AND NUTRITION			
<input type="checkbox"/> Regular			
<input type="checkbox"/> No Added Salt (2500 - 4500 mgm Na)			
<input type="checkbox"/> Liberal Diabetic (diet desserts, no sugar added)			
AMBULATION			
<input type="checkbox"/> Cane	<input type="checkbox"/> Quad cane	<input type="checkbox"/> Hemi-cane	<input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair
<input type="checkbox"/> History of falls		<input type="checkbox"/> No Assistive Device Needed	
THERAPY			
As part of the assessment process, the Physical Therapist and Occupational Therapist evaluate all participants for maintenance therapy and restorative therapy, if needed.			
Please indicate if your patient requires evaluation by the Speech Therapist.			
<input checked="" type="checkbox"/> Physical Therapy		<input checked="" type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy	
PSYCHOLOGICAL/ PSYCHIATRIC SERVICES			
Is your patient getting psychiatric or psychological treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			

CURRENT MEDICATIONS

Medications:	Dose:	Frequency:	Indication:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
OTC Medications taken at home:			
1.			
2.			
3.			
4.			

SPECIAL ORDERS

When at AFSC, my patient may be given the following medications:

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 650 mg q 4 hrs prn pain | <input type="checkbox"/> Mylanta Susp 15 ml q 4 hrs prn GI distress |
| <input type="checkbox"/> Loperamide 2 mg once daily prn diarrhea | <input type="checkbox"/> Tums 1 tab q 4 hrs prn GI distress |
| <input type="checkbox"/> Annual Flu Vaccine | <input type="checkbox"/> Other: |

First Aid for Minor Injuries

- | | |
|--|---|
| <input type="checkbox"/> Clean with normal saline | <input type="checkbox"/> Apply triple antibiotic ointment |
| <input type="checkbox"/> Cover with clean, dry, dressing | <input type="checkbox"/> Other- specify |

All participants attending Alzheimer's Family Services Center are monitored by the R.N., who will notify you of any significant changes.

- **Blood pressure and pulse are checked weekly.** If you desire an alternate frequency, please indicate: _____
- **Blood pressures < 90/60 or > 180/100, and pulse rates < 60 or > 100 will be reported to the physician.** Please indicate if you desire alternate parameters: _____
- **Participants are weighed monthly, weight changes of \pm 3 to 5 pounds per month will be reported to the physician.**
- **Diabetic participants will have their blood glucose checked if hypoglycemia or hyperglycemia is suspected.**
- **Any blood glucose < 70 or > 300 will be reported to the physician.**

TRANSPORTATION

Normal transit time is one hour or less. Occasionally, transportation may take longer, but we anticipate it will not exceed one and one-half hours. Do you approve for your patient to be on a bus for longer than one hour? Yes No

If no, please explain:

PHYSICIAN APPROVAL

My patient may attend Adult Day Health Care for the next 6 months: Yes No

Physician's Signature:	Date:
Printed MD Name:	Specialty:
Address:	Phone:
City/State/Zip:	FAX: