



Adult Day Health Care / Adult Day Program

9451 Indianapolis Avenue ~ Huntington Beach, CA 92646
 Phone (714)593-9630 ~ Fax (714) 964-5321

Health Record / Physician Report

Name:	Date of Birth:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
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TB Screening (a history of a positive PPD requires a CXR report stating there is no evidence of active TB)		
PPD date (within last year):	or CXR date (within last 4 years):	Result:

Current Diagnoses & Health Conditions	

Evidence of communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical contraindications for one way transportation that exceeds one hour? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your patient receive psychiatric / psychological treatment from a mental health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No

Allergies:

Significant Medical / Surgical History	

Problems & Needs		
<input type="checkbox"/> Auditory impairment	<input type="checkbox"/> Bladder impairment	<input type="checkbox"/> Other
<input type="checkbox"/> Visual impairment	<input type="checkbox"/> Bowel impairment	<input type="checkbox"/> Other

Ambulatory Status	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Non-ambulatory	<input type="checkbox"/> History of falls
<i>In this case, non-ambulatory means someone unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable to physically and mentally respond to a sensory signal approved by the state Fire Marshall, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers and wheelchairs.</i> (CA Health & Safety Code, section 13131)			

Assistive Devices				
<input type="checkbox"/> Single point cane	<input type="checkbox"/> Quad cane	<input type="checkbox"/> Front wheeled walker	<input type="checkbox"/> Rolling walker	<input type="checkbox"/> Wheelchair

Other Physical Limitations:

Please List All Current MEDICATIONS

Medication name	Dose	Frequency	Purpose or Indication

Orders for use at AFSC

<input type="checkbox"/> Acetaminophen 650mg q 4 hr prn pain	<input type="checkbox"/> Mylanta Susp 15ml q 4 hr prn GI distress
<input type="checkbox"/> Loperamide 2mg once daily prn diarrhea	or
<input type="checkbox"/> Annual Flu Vaccine	<input type="checkbox"/> Tums 1 tab q 4 hr prn GI distress
<input type="checkbox"/> First Aid for Minor Wounds: clean with normal saline, apply antibiotic ointment, cover with dry dressing	

Diet and Nutrition

<input type="checkbox"/> Regular diet is low in sodium & low in fat	<input type="checkbox"/> Liberal Diabetic	<input type="checkbox"/> Other
Texture will be modified to accommodate individual needs <input type="checkbox"/> Mechanical Soft <input type="checkbox"/> Puree		
Food Allergies or Restrictions:		
<input type="checkbox"/> Swallowing difficulty	<input type="checkbox"/> Dentures	<input type="checkbox"/> Other:

Therapeutic Goals

<input type="checkbox"/> Promote physical & mental well-being	<input type="checkbox"/> Enhance cognitive functioning	<input type="checkbox"/> Maintain mobility
<input type="checkbox"/> Increase daily activity level	<input type="checkbox"/> Mitigate functional decline	<input type="checkbox"/> Increase supervision & safety
<input type="checkbox"/> Provide opportunity for socialization	<input type="checkbox"/> Maximize nutritional status	<input type="checkbox"/> Other

Prognosis: Good Fair Poor

Vital Parameters for physician notification

Systolic BP < 90 or > 180 Diastolic BP < 50 or >100 Pulse rate < 50 or > 100

Blood glucose for diabetics < 70 or > 300 unless otherwise ordered

Health Care Provider Information

Signature:	Date:
Printed Name:	
Address:	Phone:
City/State/Zip:	FAX: