INFINITY ADULT DAY HEALTH CARE CENTER

5703 Corsa Avenue, Suite 100, Westlake Village, CA 91362 Phone: (818) 532-6974 Fax: (818) 688-8144

HISTORY & PHYSICAL

Patient's Name ____ ☐ Male ☐ Female DOB _____/_____/_____

☐ EHR attached (If EHR is attached, bypass any related sections below) Last Exam Date_____/_____/_____

SECTION A: DIAGNOSIS / CONDITIONS reflecting the patient's health status

***PRIMARY DIAGNOSIS (REQUIRED)_____________________________________. * INCLUDE ICD-10 CODE. Check all that apply.**

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 ____

Diseases of the Circulatory System (I00-I99)

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

Endocrine, Nutritional & Metabolic Diseases (E00-E89)

☐ Diabetes Mellitus
☐ (Type 1) ☐ (Type 2) with complications:
☐ Retinopathy ☐ Neuropathy ☐ Nephropathy
☐ Other___________________________________
☐ Hyperlipidemia ☐ Hyperthyroidism
☐ Hypothyroidism ☐ Nutritional Deficiency
☐ Other ____

Diseases of Musculoskeletal/Connective Tissues (M00-M99)

☐ Rheumatoid Arthritis ☐ Osteoarthritis
☐ Gout ☐ Osteoporosis
☐ Joint replacement __________________________________
☐ Other ____
☐ Other ____

Pulmonary / Respiratory Diseases (J00-J99)

☐ Asthma ☐ Chronic Bronchitis
☐ COPD ☐ Emphysema
☐ Other ____

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

☐ Chronic Liver Disease ☐ BPH
☐ Hemorrhoids ☐ GERD
☐ Liver disease ☐ Peptic Ulcer
☐ Chronic UTI
☐ Chronic Kidney Disease Stage _______
☐ Other ____

Mental, Behavioral & Neurodevelopmental Disorders (F01-F99)

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

Other Conditions

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

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.			

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SECTION C: PHYSICAL EXAMINATION	
HEENT	**Gastrointestinal** ☐ Incontinence Bowel
Respiratory	**Genitourinary** ☐ Incontinence Bladder
Cardiovascular ☐ Pacemaker	**Musculoskeletal**
Breast / Chest	**Integumentary**
Neurological	**Significant Physical Limitations**
All participants must show evidence of tuberculosis screening performed within 1 year prior to 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 *(medications & environmental)*	

SECTION D: VITAL PARAMETERS AND ORDERS
MD will be notified of findings outside of stated parameter range. MD may adjust by entering alternative parameter range.

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

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

SECTION E: DIET

☐ Regular (no added salt) ☐ No concentrated sweets (NCS) ☐ Low fat ☐ Other ________________________
☐ 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:

SECTION F: RISK FACTORS

Unsteady gait	☐ YES ☐ NO	Recent Hospitalization (within 6 months)	☐ YES ☐ NO
Hx of falls	☐ YES ☐ NO	Medication mismanagement	☐ YES ☐ NO
Hx of communicable disease	☐ YES ☐ NO	*If NO, patient is able to self-administer at Center*	☐ YES ☐ NO

Please describe any YES answers if details are known:

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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 (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.

☐ Transit time to and from the center may exceed one hour.

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 ____

SECTION H: PCP STANDING ORDERS (Strike out any standing order that is <u>not</u> authorized)
Chest Pain/MI: Aspirin 81 mg 2 tabs PO 1x
Diarrhea: Bepto Bismol 30mL every 30-60min
Emergency O2: At 2 - 4 lpm via nasal cannula PRN for shortness of breath. Emergency O2 to maintain O2 Sat ≥ 88%
Fever: (Most often with headache &/or body pain and other symptoms, please choose one for body temp > 100F) Tylenol 500 mg 2 tabs PO Motrin 200 mg 1 tab PO taken with food
Hypoglycemia: RBS < 70 : Orange juice + 2 tbsp regular sugar & re-check RBS after 15 minutes
Indigestion: Bepto Bismol 30mL every 30-60min
Pain Tylenol 500mg 1 tab PO Q4 hrs for mild pain or 2 tabs PO Q4 hours for moderate to severe pain Motrin taken w/food - 200 mg 1 tab PO Q4 hrs for mild pain or 2 tabs PO Q4 hours for moderate to severe pain
Non-drug pain management: Warm compress to alleviate muscle tissue discomfort. Cold compress for chronic inflammatory conditions or contusions
Skin Care: Clean with soap and water followed by drying the skin and apply A&D ointment if needed.
Wound care: Minor wound protocol, including skin tears and abrasions - Cleanse with normal saline, apply antibiotic ointment, cover with dry dressing as needed

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