PHYSICIAN'S REPORT CHECKLIST

Family Member: completes participant information & authorization sections on cover page

PCP/MD: Required to complete ALL sections

- **Cover Page:** Indicate capacity, physician name, signature, date **(required)**

- **Page 1:**
  - ✓ Diagnosis/Conditions (any & all that apply)
    Physical Examination
  - ✓ Medication Profile (must include medication, dosage, route & frequency)
    PRINTED LIST PREFERRED
  - ✓ TB Screening (**required**)
    - If **PPD** test, it must be done < 90 days from start at Town Square®
    - If **QuantiFERON** test, it must be done < 1 year from start at Town Square®
    - If **CXR**, it must be < 4 years from start at Town Square®

- **Page 2:**
  - ✓ Please answer questions 1 - 6 (top of page)
  - ✓ Standing Orders (strike through any that are not approved)
  - ✓ Vital Parameters, if other than stated
  - ✓ Diet Orders (**required**)
  - ✓ Request for Adult Day Health Care instructions
  - ✓ MD information, signature & date (bottom of Page 2)

PROVIDING A COMPLETED PHYSICIAN'S REPORT WILL AVOID ENROLLMENT DELAYS.

Your assistance is appreciated.

Thank you!

PHYSICIAN'S REPORT FOR PARTICIPANT TO ATTEND ADULT DAY HEALTH CARE (ADHC)

CENTER NAME		TELEPHONE
George G. Glenner Alzheimer's Family Centers, Inc.®		(619) 420-1703
ADDRESS	**CITY**	**ZIP CODE**
2765 Main St., Suite A	Chula Vista	91911

LICENSEE'S NAME	TELEPHONE	STATE OF CA DEPT. OF PUBLIC HEALTH LIC. NO.
George G. Glenner Alzheimer's Family Centers, Inc.®	(619) 420-1703	060000575

PARTICIPANT INFORMATION (To be completed by participant's representative)

NAME	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER
	/ /		

AUTHORIZATION FOR MEDICAL RELEASE OF MEDICAL INFORMATION
(To be completed by participant's legal representative)

NAME			TELEPHONE
			( )
ADDRESS	**CITY**	**STATE**	**ZIP**

PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES	SIGNATURE	DATE

TO BE COMPLETED BY PHYSICIAN

CAPACITY TO MAKE AND UNDERSTAND DECISIONS (Check Applicable)**:**

- ☐ Has the capacity to make and understand decisions
- ☐ Does not have the capacity to make and understand
- ☐ decisions Has fluctuating capacity

NAME OF PHYSICIAN	SIGNATURE	DATE

INSTRUCTIONS TO PCP:

1. Please complete ALL sections. Current Medication List and H&P from EHR may be attached.
2. Current TB Test or CXR is required (within 90 days of admission).

PLEASE RETURN THIS REPORT VIA FAX TO:

Enrollment Department
Office: 619-420-1703 | Direct: 619-349-5881
Fax: (619) 420-0196

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

Center Name: George G. Glenner Alzheimer's Family Centers, Inc. Center Tel: 619-420-1703 Center Fax: 619-420-0196

Address: 2765 Main St., Suite A., Chula Vista, CA 91911

Patient Name: _____ **M** ☐ **F** ☐ **DOB:** ___/___/19__ **Last Exam Date** ___/___/____

DIAGNOSES / CONDITIONS reflecting the patient's health status (Complete or attach electronic health record (EHR)

PRIMARY DIAGNOSIS (REQUIRED):

Neuro / Cognitive
☐ Alzheimer's disease ☐ Cognitive Impairment
☐ CVA ☐ Dementia
☐ Developmentally Disabled ☐ Neuropathy
☐ Parkinson's ☐ Seizures
☐ Other:

Cardiovascular
☐ Arrhythmia ☐ A-fib ☐ Anemia ☐ Angina
☐ CAD ☐ CABG ☐ CHF
☐ HTN ☐ MI ☐ PVD
☐ Other:

Endocrine / Metabolic
Diabetes Mellitus: ☐ (Type 1) ☐ (Type 2)
☐ Hyperlipidemia ☐ Hyperthyroidism
☐ Hypothyroidism ☐ Neuropathy ☐ Nephropathy
☐ Retinopathy
☐ Other:

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

Pulmonary / Respiratory
☐ Asthma ☐ Chronic Bronchitis
☐ COPD ☐ Emphysema
☐ Other:

Gastrointestinal / Genitourinary
☐ Chronic Liver Disease ☐ Chronic Kidney Disease
☐ GERD ☐ Hemorrhoids ☐ PUD ☐ BPH ☐ UTI
☐ Other:

Behavioral Health
☐ Anxiety ☐ Agitation ☐ Bipolar
☐ Depression ☐ PTSD ☐ Schizophrenia
☐ Other:
Name of other treating MD, if known:_____

Other Conditions
☐ Cataracts ☐ Difficulty Swallowing ☐ Insomnia
☐ Glaucoma ☐ Hearing Loss ☐ Low Vision
☐ Skin Breakdown ☐ Aphasia ☐ Ataxia
☐ Other:

PHYSICAL EXAMINATION (REQUIRED)

Comments	Comments
HEENT	**Gastrointestinal** ☐ Incontinence Bowel
Respiratory	**Genitourinary** ☐ Incontinence Bladder
Cardiovascular ☐ AICD ☐ Pacemaker	**Musculoskeletal**
Breast / Chest	**Integumentary**
Neurological	**Significant Physical Limitations**

Temp: **Pulse:** **Resp Rate:** **BP:** **Height:** **Weight:**

TB SCREENING (required by law within last 12 months)
PPD Date: / / **Result:** ***OR*** **CXR Date:** / / **Result:**
If no TB Screening w/in past 12 mos, PCP authorizes Center to place PPD.
☑ **If checked, Center requests PCP to complete PPD and record results.**

Allergies *(Medication & Environment):*

PRINTED LIST PREFERRED

MEDICATION PROFILE (Complete or May Attach EHR)

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

MEDICAL REQUEST FOR ADHC / CBAS

Patient Name: _____

1. Unsteady Gait? ☐ Yes ☐ No
2. Any known history of falls? ☐ Yes ☐ No
3. Medication non-compliance? ☐ Yes ☐ No
4. Recent hospitalization? (w/in 6 mo's) ☐ Yes ☐ No
5. Any significant medical history? ☐ Yes ☐ No
6. Any known evidence of communicable disease? ☐ Yes ☐ No

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

STANDING ORDERS (PCP, please strike through any orders not approved and write in alternate as desired)
Acetaminophen: 500 mg 1 tab PO Q4 hrs PRN mild pain or 2 tabs PO Q6 PRN moderate - severe pain
OTC Antacid: TUMS 750 mg - 1 tablet by mouth 1 time per week as needed for indigestion
Emergency 02: at 2 or 4 L/min. nasal cannula PRN
Ibuprofen: 200 mg 1 tab PO Q4 hrs PRN mild pain with food or 2 tabs PO Q4 hrs PRN moderate - severe pain with food
Loperamide: 2 mg 1 tab PO TID PRN for severe, ongoing diarrhea
First Aid Care: Cleanse with normal saline, apply antibiotic ointment (not Neosporin), cover with dry dressing PRN
Non-enteric coated ASA: 81 mg, 2 tabs PO ASAP PRN for suspected stroke or acute coronary syndrome
Tuberculin PPD: 0.1 mg ID in forearm, read 48-72 hrs (if no screen within last 12 months and if test offered at ADHC center)
Milk of Magnesia (magnesium hydroxide): 15 ML (1 tablespoon) PO BID PRN for mild constipation until relief of symptoms or 30 ML (2 tablespoons) PO BID PRN for severe constipation until relief of symptoms

VITAL PARAMETERS	**DIET ORDERS**
MD may adjust by striking thru and entering desired parameter(s) for notification.	☐ Regular ☐ No added salt ☐ No Concentrated Sweets ☐ Other: _____ Center may deviate from No Concentrated Sweets diet order up to two times a month (special occasions) **DIET TEXTURE:** ☐ Regular ☐ Chopped ☐ Puréed ☐ Thickened Liquids ☐ Other: _____ Any known food restrictions? ☐ Yes ☐ No Specify:
Systolic Blood Pressure: 100 - 160 Diastolic Blood Pressure: 50 - 100 Pulse: 50 - 110 Random Blood Glucose: 90 - 250	
Note: NIDDM RBS monthly/IDDM RBS weekly/prn symptoms *unless otherwise ordered.*	
Alternative orders:	

REQUEST FOR ADULT DAY HEALTH CARE / CBAS SERVICES SECTION (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.

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 more than 60 minutes? ☐ None
3) Overall health prognosis? _____
4) Overall therapeutic goals? _____

DO NOT RESUSCITATE ORDER ON FILE? ☐ YES ☐ NO

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

Print PCP Name: _____

Signature: _____ Date: _____

PCP Tel: _____ PCP Fax: _____ PCP Email: _____