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

PATIENT HISTORY AND PHYSICAL

Name: ____**M** ☐ **F** ☐ **DOB:** _____________ **Date of Exam** ________
Street Address:_____________________________________ **City:**__________________ **Zip:**____________
Telephone number:___________________________________
Emergency Contact __________________________________ **Phone Number :** _________________________

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

Neuro / Cognitive	**Cardiovascular**
☐ Alzheimer's disease ☐ Cognitive Impairment ☐ CVA ☐ Dementia ☐ Developmentally Disabled ☐ Neuropathy ☐ Parkinson's ☐ Seizures ☐ Other:	☐ Arrhythmia ☐ Anemia ☐ Angina ☐ CHF ☐ HTN ☐ PVD ☐ CAD ☐ Other:
Endocrine / Metabolic *Diabetes Mellitus:* ☐ IDDM ☐ NIDDM Please include most recent A1C reading:____________ ☐Hyperlipidemia ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Neuropathy ☐ Other: ☐ Retinopathy	**Musculoskeletal** ☐ Chronic Back Pain ☐ Joint Replacement ☐ Osteoarthritis ☐ Osteoporosis ☐ Spinal Stenosis ☐ Other:
Pulmonary / Respiratory ☐ Asthma ☐ Chronic Bronchitis ☐ COPD ☐ Emphysema ☐ Other:	**Gastrointestinal / Genitourinary** ☐ Chronic Liver Disease ☐ Chronic Kidney Disease ☐ GERD ☐ Hemorrhoids ☐ Incontinence ☐ PUD ☐ UTI ☐ Other:
Behavioral Health ☐ Anxiety ☐ Bipolar ☐ Depression ☐ Schizophrenia ☐ Other:	**Other Conditions** ☐ Cataracts ☐ Difficulty Swallowing ☐ Insomnia ☐ Glaucoma ☐ Hearing Loss ☐ Skin Breakdown ☐ Other:

ADDITIONAL DIAGNOSES / CONDITIONS: ____
____
____

PHYSICAL EXAMINATION (**Complete or attach EHR**)

	WNL	**Comments**		**WNL**	**Comments**
HEENT	☐		**Gastrointestinal**	☐	
Respiratory	☐		**Genitourinary**	☐	
Cardiovascular	☐		**Musculoskeletal**	☐	
Breast / Chest	☐		**Integumentary**	☐	
Neurological	☐		**Other**:		
Significant Physical Limitations: ☐ Yes ☐ No					

MEDICATION PROFILE (Complete or Attach EHR)

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

TB SCREENING as Required by Law (Within previous 12 months)

Temp:	Pulse	Resp Rate	BP	Height	Weight
☐ PPD Date:	Result:	OR CXR Date:		Result:	

1. Unsteady Gait ☐ Yes ☐ No
2. Any known history of falls? ☐ Yes ☐ No
3. Any significant medical history? ☐ Yes ☐ No
4. Any known evidence of communicable disease? ☐ Yes ☐ No

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

Allergies: (Medication & Environment) ☐ None List:________________________________

STANDING ORDERS (*Strike-through orders not approved and write in alternate orders*)

Emergency O2 at 2 or 4 L/min. nasal cannula PRN; **ProAir** inhaler 2 puffs QD for SOB.
BS check by finger stick 1xwk and PRN for s/s Hypo/Hyperglycemia; **Dex 4** (Fast Acting Glucose) 1-2 tabs chew till dissolved if blood sugar is < 60 mg/mg.
Annual influenza virus vaccine injection per CDC recommendations *(if offered at ADHC center)*
Antacid : **Pepto-Bismol, Mylanta, Maalox, Antacid 15-40 ML** PO Q4 hours PRN indigestion or two tabs PO Q4 hours PRN indigestion; **Tums/Gas X/Gas Ban** 2tabs chew for bloated or gas.
Ibuprofen 200 mg 1 tab PO Q4 hrs prn mild pain w/ food or 2 tabs PO Q4 hrs prn moderate-severe pain w/ food. **Acetaminophen 500 mg** tab PO Q4 hrs prn mild pain or 2 tabs PO Q4 hrs prn moderate-severe pain. **Salon Pas** patch PRN for pain.
Food Supplement: 1-2 cans/bottles of **Glucernia** for diabetic patient; or Ensure/Kirkland Complete Nutrition Shake for regular patient.
NTG 0.4 mg S/L for Chest Pain: 1 dose every 5 min. x 3 doses. If pt still having chest pain sent to the ER.
Minor wound protocol: cleanse w/ normal saline; apply antibiotic (**Neosporin**) ointment; cover with dry dressing prn. **Antimicrobial Skin Cream:** as lotion PRN. **Eye Irritation:** Eye Wash (Eye irrigation Solution).
Non-enteric coated ASA 81 mg per MI protocol PO 1X
Antidiarrhea Meds: Imodium, Kaopectate 2-4 tabs Q4hrs PRN for diarrhea. If in liquid form, 15-30 ML. **Benadryl** 25 mg PRN for itching or allergic reaction, **Hydrocortisone, Anti-itch&Skin Protectant Cream** 1% cream PRN for itching **Constipation: Miralax/Laxaclean** 17 grams PO QD. **Fiber Therapy, Citrucel (Methylcellulose)** 1 teaspoon mixed with 8 oz of water PO.
Meclizine 12.5 mg 1tab PO QD prn for dizziness. **DayQuil** (Cold/Flu) 30ml Q4hrs for cold and flu; 2 tabs Q4hrs. **Cough Drop** (Halls, Ricola, CVS, Vicks', Robitussion..etc.) PRN for cough. **Additional or Alternative:**

VITAL PARAMETERS	DIET ORDER
MD may adjust by striking thru and entering desired parameter(s) for notification.	☐ Regular ☐ No added salt ☐ Low Concentrated Sweets ☐ Liberal Renal Diet(low K & Phosphorus) ☐ Other:____________________
	DIET TEXTURE ☐ Regular ☐ Chopped ☐ Puréed ☐ Thickened Liquids ☐ Other: ________________________
Systolic Blood Pressure: 80 - 170	
Diastolic Blood Pressure: 50 - 110	Any known food restrictions? ☐ Yes ☐ No Specify:____________________
Pulse: 50 - 110	ADHC hot meal consists of NCS 1200 Kcal, Bland with high fiber, NAS (low sodium), low saturated fat, and low cholesterol
Random Blood Glucose: 60 - 300	Center may deviate from low concentrated sweets diet order up to two times a month (special occasions)

Note: NIDDM RBS monthly/IDDM RBS weekly/prn symptoms *unless otherwise ordered.*

Alternative orders:

REQUEST FOR ADULT DAY HEALTH CARE SERVICES SECTION:

All patients receive the following on each day of attendance skilled nursing, social services, personal care, 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 services are ongoing unless otherwise indicated.

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

The patient has one or more chronic or post acute conditions that require monitoring, treatment or intervention and without which there is a high potential for further deterioration and may require emergency room, hospitalization institutionalization.

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

PCP Print Name: ____________________

PCP Signature: ____________________ Date: __________

PCP Phone __________ PCP Fax: __________ PCP Email: __________

PCP Address: ____________________ City/ Zip Code: __________