isabella
a member of MJHS Health System

Adult Day Health Care
Physician Admission Medical Assessment

525 Audubon Avenue, NY, NY 10040 | (212) 342-9813

Patient Last Name_____ First Name_____ M.I.___ Sex___

Home Address_____ City_____ State _____ Zip_____ Phone (_____)_____

Age_____ Date of Birth_____ Date of Exam _____

DIAGNOSIS

Primary/Date of _____

Secondary _____

_____

PPD Result: _____ Date Given: _____

CXR Result: Date:

Current Mental Status (Including orientation, Psych. Dx, etc.):_____

_____

Vital Signs: HT _____ WT _____ BP _____

T _____ P _____ R _____

Allergies: _____

_____

MEDICATIONS (include dose, route & frequency)

_____

_____

_____

Treatments: (include glucose testing, frequency, parameters and sliding scale):

_____

_____

Standing Orders (please (✓) applicable orders)

- ☐ Tylenol 325 MG. TABS ii P.O. Q4H PRN Pain/Fever (101)
- ☐ Maalox 30 CC P.O. Q4H PRN For Ingestion
- ☐ Kaopectate 30 CC P.O. Q4H For Diarrhea
- ☐ N.T.G. 1/150 gr i Sub Lingual PRN For Chest Pain (Repeat Q 5 minutes for 15 minutes)
- ☐ PRN O^2

FUNCTIONAL STATUS:	Independent	W/Assist	Unable	Assistance Devices (Specify)
Ambulation	☐	☐	☐	☐
Transfers	☐	☐	☐	☐
Feeding	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
W/C Propulsion	☐	☐	☐	☐

Bowel	☐ Continent	☐ Incontinent	**Sight**	☐ Normal	☐ Impaired
Bladder	☐ Continent	☐ Incontinent	**Hearing**	☐ Normal	☐ Impaired
Hx of Falls	☐ Yes	☐ No	**Speech**	☐ Normal	☐ Impaired
Hx of Wandering Behavior	☐ Yes	☐ No			

Recommendation For Rehab: ☐ PT-Eval. & Tx. (reason) _____

☐ OT -Eval. & Tx. (reason) _____

☐ Speech -Eval. & Tx. (reason) _____

(Please attach specifics regarding rehab recommendations):

Any Restriction On Physical Activity: Yes No If Yes Explain: _____

☐ Refer to Isabella Clinics prn (eg. Podiatry)

DIET ☐ Regular ☐ NCS (No Concentrated Sweets) **Diet** ☐ Renal Diet ☐ NAS (No Added Salt Diet)

Date	HGB	HCT	WCB	PLT	GLU	K+	NA+	CL-	BUN	CREAT

EKG:_____ **Other significant Labs:** Cholesteral, etc._____

I certify that the above named patient is medically appropriate for participation in Isabella Adult Day Health Care Program. S/he is free from the infections state of any communicable disease. Because of the anticipated benefits, I prescribe this program for him/her.

I am aware of and in agreement with this referral for medical day care and recognize that the above named patient needs at least 30 days of care and service

M.D. Name (Print) _____ **Signature** _____

Address _____ **Phone Number (Extension)** _____

Date _____ **License #** _____

M.D.'s Fax Number _____ **Hospital/Clinic** _____

PLEASE FAX TO (212) 342-9805