isabella
Welcome to our family.

ADULT DAY HEALTH CARE 525 Audubon Avenue, NY, NY 10040 (212) 342-9813

PHYSICIAN ADMISSION MEDICAL ASSESSMENT

Patient's Name: _____ **Sex:** _____
(LAST) (FIRST) (M.I.)

Patient's Home Address: _____
(STREET/APT #) (CITY) (STATE) (ZIP CODE) (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: Cholesterol, 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 services.

M.D. NAME (PRINT) | **SIGNATURE**

ADDRESS | **PHONE NUMBER (EXTENSION)**

DATE | **LICENSE #**

M.D.'S FAX NUMBER | **HOSPITAL / CLINIC**

PLEASE FAX TO: (212) 342-9805