isabella
Welcome to our family.

ADULT DAY HEALTH CARE 525 Audubon Avenue, New York, NY 10040 (212) 342-9813 Fax (212) 342-9805

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:** _____

Primary Diagnosis and ICD10 Codes:
Diagnosis: _____ **ICD10 Code:** _____
Diagnosis: _____ **ICD10 Code:** _____
Diagnosis: _____ **ICD10 Code:** _____
Diagnosis: _____ **ICD10 Code:** _____
Diagnosis: _____ **ICD10 Code:** _____
Diagnosis: _____ **ICD10 Code:** _____
Diagnosis: _____ **ICD10 Code:** _____
Diagnosis: _____ **ICD10 Code:** _____
*Please attach complete list of Diagnosis and Codes if amount exceeds above.

Medications (attach current medication list):
_____
_____
_____
_____
_____
Medication Administration: ☐ Self ☐ Home ☐ Nurse in Program
Medisets prefilled: ☐ VNS ☐ Program

PPD Result: _____ **Date Read:** _____
CXR Result: _____ **Date:** _____

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

CURRENT MENTAL STATUS (Including orientation, Psych. Dx, etc.): _____
_____

PAIN: LEVEL/LOCATION: _____
_____

VITAL SIGNS:
HT _____ **WT** _____ **BP** _____
T _____ **P** _____ **R** _____
Allergies: _____

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 Indigestion
☐ 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

Current FLU Vaccine Status:
Vaccination Date: _____
☐ Allergy to Flu Vaccine ☐ Refused Vaccine

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

Bowel Continent ☐	Incontinent ☐	Vision	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: ☐ Speech ☐ PT ☐ OT **Reason for Rehab:** _____
(Please attach specifics regarding rehab recommendations):
Any Restriction On Physical Activity: Yes ☐ No ☐ **If Yes Explain:** _____

DIET: ☐ Regular ☐ NCS Diet ☐ Renal Diet ☐ NAS Diet ☐ Low Fat / Low Cholesterol Diet

DATE	HGB	HCT	WBC	PLT	GLU	K+	NA+	CL-	BUN	CREAT

EKG: _____ **OTHER SIGNIFICANT LABS:** Cholesterol, etc.

Able to self medicate during attendance in program? ☐ Yes ☐ No If "NO", RN may administer medication(s) during attendance in program when required or when requested by responsible party: ☐ Yes ☐ No

I certify that the above named patient is medically appropriate for participation in Isabella ADHC 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 has the need for continued stay in Isabella's Adult Day Health Care Program.

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

ADDRESS | M.D.'S PHONE NUMBER | M.D.'S FAX NUMBER

HOSPITAL / CLINIC | LICENSE #

PLEASE DATE & FAX COMPLETED FORM TO: (212) 342-9805