OC Anaheim ADHC / CBAS

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PHYSICIAN'S HEALTH ASSESSMENT AND AUTHORIZATION FOR TREATMENT FORM

Patient's Name: DOB: ____/____/____	Gender: ☐ M ☐F	Tel:
PPD Date: ____/____/____ ☐ Positive ☐ Negative	**CXR:** Date ____/____/____ ☐ Positive ☐ Negative	
Temp: Pulse: Resp: BP: mmHg	Height: Weight:	

Physical Examination (Complete or attach electronic health record (EHR): CURRENT MEDICAL EXAM

Cardiovascular: ☐pacemaker Date of implant: Rate:	**Neurological:**
Musculoskeletal:	**Respiratory:**
Integumentary:	**Genitourinary:**
H.E.ENT:	**Gastrointestinal:**
Hx. Seizures: ☐ **Yes** ☐ **No**	**Hx. Falls**: ☐ Yes ☐ No

Any indication of communicable disease: ☐ Yes ☐ No If YES please explain:

Diet Order: ☐Regular House diet (Low salt, Low Fat, Low Cholesterol) ☐ **Diabetic/NCS** ☐ **Renal**
☐ **Other: _____**

Diet Texture: ☐Regular ☐Chopped ☐Pureed ☐Thickened liquids ☐Other_____

TRANSPORTATION: Are there any medical contraindications for one-way transportation more than one hour?
☐ **No** ☐ **Yes If YES, please specify: _____**

MEDICATION PROFILE (Complete or attach electronic health record (EHR)):

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

Can the patient self-administration of medication? ☐ Yes ☐ No

Allergies:

PRN medication at center: I authorized OC Anaheim ADHC to administer the following PRN medication:

☐ **ALL OF THE PRN MEDICATIONS**

☐ **Clonidine HCL 0.1mg PO If SBP>180mmHg; other _____mmHg**
☐ **Acetaminophen 500 mg. 1- or 2-tabs PO Q 3-4 hours**
☐ **Aspirin EC 81mg PO**
☐ **NTG 0.4mg SL PRN chest pain (1dose per 3 min x 3 doses, then 911 w/no relief).**
☐ **Glucose chewable Tabs 4g PO if BS <50mg/dl; other _____mg/dl.**
☐ **Oxygen 2-3 L via nasal cannula**
☐ **Tums Ultra Strength 1000mg PO 2-3tabs**
☐ **Loperamide HCL 2mg PO**
☐ **Benadryl 25mg PO 1-2tabs 4-6H**
☐ **Mylanta 30 cc PO q4h**
☐ **Hydrocortisone Plus Cream 1%**
☐ **Triple Antibiotic Ointment**
☐ **Hydrogen peroxide Solution1%**
☐ **wound wash saline**

DIAGNOSIS & ICD CODE Patient's Name: _____ DOB: _____

V	Behavioral	ICD-10	V	Endocrine/ Metabolic	ICD-10	V	Gastrointestinal/ Genitourinary	ICD-10
	Anxiety D/O NOS	F41.9		Hypothyroidism	E03.9		BPH	N40.0
	Bipolar Disorder	F31.9		Hyperthyroidism	E05.9		Constipation	K59.00
	Delusion Disorder	F22		**Neuro/Cognitive**	**ICD-10**		Chronic liver disease	I12.9
	Depression	F32.9		Alzheimer's Disease	G30.9		CKD	N18.9
	Post-Traumatic Stress D/O	F43.12		Dementia	F03.90		GERD	K29.90
	Schizophrenia	F25.9		Peripheral Neuropathy	G64		Gastritis	K29.70
	Insomnia	G47.00		Headache	G44.86		Dyspepsia	K30
	Cardiovascular	**ICD-10**		Dizziness/Vertigo	R42		Incontinence: • Bladder	R32
	Angina	I20.9		Neuropathic pain	M79.63		Overactive Bladder	N32.81
	ASHD	I25.10		Sciatica	M54.3		UTI	N39.0
	Atrial Fibrillation (AF)	I48.91		Parkinson disease	G20		Hepatitis B carrier	Z22.51
	Arrhythmia	I49.9		**Musculoskeletal**	**ICD-10**		**Pulmonary/Respiratory**	**ICD-10**
	CAD	I25.10		DJD	M15.0		Asthma	J45.909
	CABG	I25.810		Hip Fx/Replacement	M84.459		COPD	J44.9
	CHF	I50.9		Osteoporosis (OP)	M81.0		Chronic Bronchitis	J42
	Chest pain	R07.9		Osteoarthritis (OA)	M19.90		Dyspnea	R06.0
	CVA:	I63.9		Low Back Pain	M54.5		Emphysema	J43.9
	Hyperlipidemia	E78.5		Knee Pain	M25.569		Pneumonia	J18.9
	Myocardial Infarction	I25.2		Gout	M10.9		**Other Medical Conditions**	**ICD-10**
	PVD	I73.9		Lumbar Stenosis	M48.061		Glaucoma	H40.9
	Arrhythmia	I49.9		Falls	Z91.81		Cataract	H25.9

***Please check each box for Dx of HTN or DMII**

☐ HTN: I10	☐ DM II: E11.65	Other Dx:
BP check based on attendance or PRN **Standard range: 90/60-140/80mmHg** **Notify physician if** **BP: <90/50 or >170/100mmHg** **HR: < 50 or > 100 BPM** **☐Other Range: _____ to_____**	FBS check frequency: ☐ Daily (based on attendance) ☐Weekly • Monthly • PRN **Standard range: 70-110mg/dl** **Notify physician if** **FBS: < 60 or >300 mg/dL** • Other Range: _____ to_____	

REQUEST FOR ADHC /CBAS SERVICES SECTION (must be completed and signed by PCP):

All patients receive the following on each day of the 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.

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.

Name of PCP (Print):	Signature of PCP:
Date	Address
Phone Number	Fax Number