ForeverYoung
ADULT CENTER

PHYSICAL HEALTH EXAMINATION

I, _____, MD (_____) certify that
Physician License #

_____ was examined by me on _____.
Patient Date

The person in reference has been evaluated for physical condition and I find this person to show no evidence of communicable disease.

TUBERCULIN EXAMINATION

☐ Mantoux Method TB Skin Test ☐ Chest X-Ray

Exam Date: _____
Reading Date: _____
Result: _____

RECOMMENDATIONS:

_____

_____

_____

_____

_____ _____
Physician Signature Date

Office Address: _____

Office Phone: _____ Office Fax: _____

600 W North Blvd Suite A, Leesburg, FL 34748 | **Web Site**: www.foreveryoungac.com
Phone 352-320-3305 **Fax** 407-850-2648 **Emial** administration@foreveryoungac.com

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PARTICIPANT'S HEALTH ASSESSMENT

Name: _____ Date of Birth: _____
Known Allergies: _____
Height: _____ Weight: _____

Medical History: _____

_____

_____

Physical/Sensory Limitations: _____

_____

Cognitive/Behavioral Status: _____

Is the participant currently afflicted with a contagious disease?

☐ Yes ☐ No

If yes, please specify: _____

Is the participant able to self-administer medication while attending the facility?

☐ Yes ☐ No

Does the participant have any psychiatric history?

☐ Yes ☐ No

If yes, please specify: _____

Is there a medical reason that the participant should be restricted from participating in any activities (e.g., walking, exercise, dancing, etc.)?

☐ Yes ☐ No

If yes, please specify: _____

If there is anything else that might be pertinent to the care of the participant, please comment below:

_____

_____

_____

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PARTICIPANT HEALTH ASSESSMENT (continued)

Dietary Restrictions and Prescription Information

Name: _____ Date of Birth: _____

☐ Regular ☐ Diabetic ☐ Low Sodium ☐ Low Fat/Cholesterol ☐ Other: _____

Forever Young Adult Center provides a regular diet that includes breakfast, lunch, and dinner. We focus on the minimal amount of salt, fat, and cholesterol.

Please list all current medications, including dosage and frequency. Please also indicate whether the medication should be taken with food or if there are foods the participant should avoid. Please attach any pertinent lists.

Medication	Dosage	Frequency	With Food	Avoid
			Y // N	
			Y // N	
			Y // N	
			Y // N	
			Y // N	

I certify that I have reviewed the health assessment and examined this person and found him/her to be physically able to participate in the adult day care.

Date of examination: _____

_____ _____

Physician Signature

Office Address: _____

Office Phone: _____ Office Fax: _____

Medical License # _____

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MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

A. PATIENT INFORMATION

Gender: ☐ Male ☐ Female
Hispanic Ethnicity: ☐ Yes ☐ No
Race: ☐ White ☐ Black ☐ Other: _____
Language: ☐ English ☐ Other:

B. SIGHT HEARING

☐ Normal ☐ Impaired ☐ Normal ☐ Impaired
☐ Blind ☐ Deaf ☐ Hearing Aid L R

C. DECISION MAKING CAPACITY (PATIENT):

☐ Capable to make healthcare decisions ☐ Requires a surrogate

D. EMERGENCY CONTACT

Name: _____ Name: _____
Phone: Phone:

E. MEDICAL CONDITION / RECENT HOSPITAL STAY

Primary Dx at discharge:
Reason for transfer (Brief Summary):

Surgical procedures performed during stay: ☐ None

Other diagnoses:

F. INFECTION CONTROL ISSUES

PPD Status: ☐ Positive ☐ Negative ☐ Not known
Screening date: _____
Associated Infections/resistant organisms:

☐ MRSA Site: _____
☐ VRE Site: _____
☐ ESBL Site: _____
☐ MIDRO Site: _____
☐ C-Diff Site: _____
☐ Other: Site: _____

Isolation Precautions: ☐ None
☐ Contact ☐ Droplet ☐ Airborne

G. PATIENT RISK ALERTS

☐ None Known ☐ Harm to self ☐ Difficulty swallowing
☐ Elopement ☐ Harm to others ☐ Seizures
☐ Pressure Ulcers ☐ Falls ☐ Other: _____

RESTRAINTS: ☐ Yes ☐ No
Types:

Reasons for use:

ALLERGIES: ☐ None Known ☐ Yes, List below:

Latex Allergy: ☐ Yes ☐ No Dye Allergy/Reaction: ☐ Yes ☐ No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
DO NOT Resuscitate (DNR)	☐ Yes	☐ No
DO NOT Intubate	☐ Yes	☐ No
DO NOT Hospitalize	☐ Yes	☐ No
No Artificial Feeding	☐ Yes	☐ No
Hospice	☐ Yes	☐ No

I. TRANSFERRED FROM

Facility Name:
Date: Unit:
Phone: Fax:
Discharge Nurse: Phone:
Admit Date: Discharge Date:
Admit Time: Discharge Time:

J. TRANSFERRED TO

Facility Name:
Address 1:
Address 2:
Phone: Fax:

K. PHYSICIAN CONTACTS

Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): ☐ Yes ☐ No

☐ Anticoagulants	Date:	Time:
☐ Antibiotics	Date:	Time:
☐ Insulin	Date:	Time:
☐ Other:	Date:	Time:

Has CHF diagnosis: ☐ Yes ☐ No
If yes; new/worsened CHF present on admission?
☐ Yes ☐ No
Last echocardiogram: Date: LVEF %

On a proton pump inhibitor? ☐ Yes ☐ No
If yes, was it for: ☐ In-hospital prophylaxis and can be discontinued
☐ Specific diagnosis:

On one or more antibiotics? ☐ Yes ☐ No
If yes, specify reason(s):

Any critical lab or diagnostic test pending at the time of discharge? ☐ Yes ☐ No
If yes, please list:

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10):
Last administered: Date: Time:

N. FOLLOWING REPORTS ATTACHED

☐ Physicians Orders ☐ Treatment Orders
☐ Discharge Summary ☐ Includes Wound Care
☐ **Medication Reconciliation** ☐ Lab reports
☐ Discharge Medication List ☐ X-ray ☐ EKG
☐ PASRR Forms ☐ CT Scan ☐ MRI
☐ Social and Behavioral History

ALL MEDICATIONS: (MAY ATTACH LIST)

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

O. VITAL SIGNS

Date: Time Taken:

HT: WT:

Temp: BP:

HR: RR: Sp02:

P. PATIENT HEALTH STATUS

Bladder: ☐ Continent ☐ Incontinent

☐ Ostomy ☐ Catheter Type: _____ **date inserted:** _____

Foley Catheter: ☐ Yes ☐ No **If yes, date inserted:** _____

Indications for use:

☐ Urinary retention due to: _____

☐ Monitoring intake and output

☐ Skin Condition: _____

☐ Other: _____

Attempt to remove catheter made in hospital? ☐ Yes ☐ No

Date Removed: _____

Bowel: ☐ Continent ☐ Incontinent ☐ Ostomy

Date of Last BM: _____

Immunization status:

Influenza: ☐ Yes ☐ No Date: _____

Pneumococcal: ☐ Yes ☐ No Date:

Q. NUTRITION / HYDRATION

Dietary Instructions:

Tube Feeding: ☐ G-tube ☐ J-tube ☐ PEG

Insertion Date:

Supplements (type): ☐ TPN ☐ Other Supplements:

Eating: ☐ Self ☐ Assistance ☐ Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

☐ PT - *Frequency:*

☐ OT - *Frequency:*

☐ Speech - *Frequency:*

☐ Dialysis - *Frequency:*

S. PHYSICAL FUNCTION

Ambulation:
- ☐ Not ambulatory
- ☐ Ambulates independently
- ☐ Ambulates with assistance
- ☐ Ambulates with assistive device

Transfer:
- ☐ Self
- ☐ Assistance
- ☐ 1 Assistant
- ☐ 2 Assistants

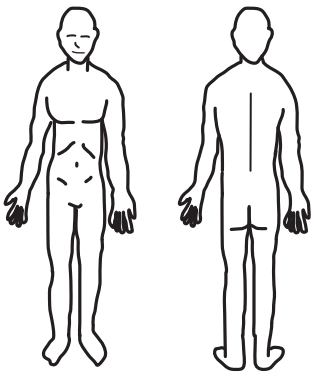
Devices:
- ☐ Wheelchair (type):
- ☐ Appliances:
- ☐ Prosthesis:
- ☐ Lifting Device:

Weight-bearing:

Left:
☐ Full ☐ Partial ☐ None

Right:
☐ Full ☐ Partial ☐ None

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers
(Indicate stage and location(s) of lesions using corresponding number:

1.

2

3.

List any other lesions or wounds:

U. MENTAL / COGNITIVE STATUS AT TRANSFER

☐ Alert, oriented, follows instructions

☐ Alert, disoriented, but can follow simple instructions

☐ Alert, disoriented, and cannot follow simple instructions

☐ Not Alert

V. TREATMENT DEVICES

☐ Heparin Lock - Date changed:

☐ IV / PICC / Portacath Access - Date inserted:

Type: _____

☐ Internal Cardiac Defibrillator ☐ Pacemaker

☐ Wound Vac

☐ Other: _____

Respiratory - Delivery Device: ☐ CPAP ☐ BiPAP

☐ Nebulizer ☐ Other: _____ ☐ Nasal Cannula

☐ Mask: Type _____

☐ Oxygen - liters: ____% ☐ PRN ☐ Continuous

☐ Trach Size: _____ Type: _____

Ventilator Settings: _____

☐ Suction

W. PERSONAL ITEMS

☐ Artificial Eye	☐ Prosthetic	☐ Walker
☐ Contacts	☐ Cane	☐ Other
☐ Eyeglasses	☐ Crutches	
☐ Dentures	☐ Hearing Aids	
☐ U ☐ L ☐ Partial	☐ L ☐ R	

X. COMMENTS (Optional)

Signature: _____

Printed Name: _____

Y. PHYSICIAN CERTIFICATION

☐ I certify the individual requires nursing facility (NF) services.

☐ The individual received care for this condition during hospitalization.

☐ I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Rehab Potential (check one)
☐ Good ☐ Fair ☐ Poor

Effective date of medical condition _____

Physician/ARNP Signature: _____ Date: _____

Printed Physician/ARNP Name & Title: _____ Phone Number: _____

Person completing form: _____ Phone Number: _____ Date: _____