



340 Rancheros Dr. Suite 196  
 San Marcos, CA 92069  
 Phone: (760) 682-2424  
 Fax: (760) 471-5104

## HEALTH RECORD

Name: \_\_\_\_\_ Gender:  Female  Male  
 Address: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date examined by MD: \_\_\_\_\_

### Consent for Release of Information

*I, the undersigned, hereby consent to and authorize release of any and all medical, social, psychological, psychiatric, neurological and other information to AmeriCare Adult Day Health Care Center for inclusion in the individual's record.*

Signature of Participant: \_\_\_\_\_ Date: . \_\_\_\_\_

PRIMARY DIAGNOSIS	ICD-10 CODE	SECONDARY DIAGNOSIS	ICD-10 CODE
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

### **Current Medical Examination** (within last 90 days prior to ADHC enrollment)

General:	Lungs:
H.E.E.N.T.	Heart:
Mouth:	Abdomen:
Thorax:	Genitourinary:
Breast:	Musculoskeletal:
Lymphatic:	Rectal:

### **Current Medications** (Please print)

Medication	Dose	Frequency	Indication

Patient is okay to self-administer any of the above medications while at the ADHC as needed.  
 Yes  No

**Drug allergies:** \_\_\_\_\_ **Food allergies:** \_\_\_\_\_

Any indication of communicable disease? \_\_\_\_\_

Last PPD test: \_\_\_\_\_ Last Chest X-Ray: \_\_\_\_\_ Results of TB: \_\_\_\_\_

I approve an order for the ADHC RN to administer the PPD Test  Yes  No

## HEALTH RECORD (CONTINUED)

**Ambulation**

- Ambulatory       Non-Ambulatory       Ambulates with Assistance  
 No devices       Cane       Quad Cane       Walker       Wheelchair

**Vitals**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Temperature: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Heart Rate: \_\_\_\_\_ Respiratory: \_\_\_\_\_

History of Seizures:       Yes       No

**Diet and Nutrition**

- Regular (Regular diet is a low fat/cholesterol NAS, 2-4g max)  
 Liberal Diabetic (diet dessert, no sugar added)  
 Other (please specify): \_\_\_\_\_

I authorize my patient to be served a regular diet up to 2X per month for special events

- Yes       No

**OTC Medications**

These medications will remain current during the participants' enrollment at AmeriCare unless DC'd by MD. For mild pain, stomach upset, coughing or intestinal distress, my patient may be given the following:

- |   |   |
|---|---|
| <b>Pain</b><br><input type="checkbox"/> Ibuprofen, 200mg, 2 tabs, q6hr PRN pain<br><input type="checkbox"/> Robitussin or equivalent, as directed, q4hr PRN cough<br><input type="checkbox"/> Tylenol or equivalent, 500mg, 2 tabs, q8hr PRN headache, pain or temp >99°F | <b>Stomach upset/Intestinal distress</b><br><input type="checkbox"/> Antacid, as directed, q4hr PRN stomach upset<br><input type="checkbox"/> Laxative (M.O.M), as directed, qd PRN constipation<br><input type="checkbox"/> Pepto Bismol or equivalent, as directed, q30-60min, PRN diarrhea |
|---|---|

**Is there any significant medical history and allergies the AmeriCare ADHC needs to know?**

**Special Order**

*All participants attending AmeriCare ADHC will have their BP monitored and Diabetics will have a RBS check by the Nurse on days of attendance. Our Nurse will recheck any abnormal readings and notify you of any significant changes when patient is:*

**Symptomatic w/RBS ↓70 & ↑300 and Symptomatic w/ BP ↓90/50 & ↑160/90 or at discretion of RN**

**Other Orders:** \_\_\_\_\_

**Transportation**

Normal transit time is 1 hour. Are there any contradictions to ride longer than 1 hour?

- Yes       No      If "Yes," please explain: \_\_\_\_\_

### Physician's Request/Recommendation

<input checked="" type="checkbox"/> <i>I request/recommend my patient to attend AmeriCare Adult Day Health Care for the next 180 days. This includes having Nursing, PT, OT, ST, RD, SW &amp; Activities assessments &amp; treatments as indicated for maintenance and/or restorative purposes. In addition, nurses may dispense any daytime medications that are prescribed for my patient at the center.</i>	
<b>Physician's Signature:</b>	<b>Date:</b>
<b>Printed name:</b>	<b>Specialty:</b>
<b>Address:</b>	<b>Phone:</b>
	<b>Fax:</b>