Tucker’s Adult Health Day Care

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Adult Health Day Care Physicians Assessment Form

PARTICIPANTS NAME:______________________ DOB: ______________

SOCIAL SECURITY NUMBER: ______________ MEDICAID NUMBER: ______________

DIAGNOSIS: PRIMARY: ______________________

(CURRENT) SECONDARY: ______________________

MEDICAL HISTORY: ______________________

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PHYSICAL EXAMINATION

VITAL SIGNS: T (   ) P (   ) R (   ) BP (   )

LABORATORY FINDINGS: ______________________

____

EENT: ______________________

RESPIRATORY: ______________________

CARDIOVASCULAR: ______________________

GASTROINTESTINAL: ______________________

GENITOURINARY: ______________________

MUSCULOSKELETAL: ______________________

SKIN: ______________________

ENDOCRINE: ______________________

ALLERGIES:______________________

DIET: ______________________

____

SPECIAL CARE REQUIREMENTS (List any daily activity limitations special therapies or special care requirements)

____

Is the individual capable of administering their own medications? (   ) Yes (   ) No

MEDICATIONS	DOSE/FREQ/ROUTE	MEDICATIONS	DOSE/FREQ/ROUTE

THE FOLLOWING PROCEDURES MAY BE PERFORMED AT AN ADULT HEALTH DAY CARE BY A NURSE WHO WILL CALL FOR DIRECT CARE ORDERS:

Please indicate frequency per week or month. __________ Ostomy Care __________ Catheter Care __________ Tube Feeding __________ Decubitus/Wound Care __________ Tracheotomy Care

I attest to the necessity of the following services for this CLTC program participant:

ADULT DAY HEALTH CARE __________ ADULT DAY HEALTH CARE NURSING __________

RESPITE CARE NURSING HOME/HOSPITAL __________ RESPITE CARE COMMUNITY RESIDENTIAL CARE FACILITY __________

SIGNATURE OF PHYSICIAN ______________________ DATE ______________

SIGNATURE OF CASE MANAGER ______________________ DATE ______________

DATE SENT ______________________ INITIALS ______________