El Camino Adult Day Health Care Center

15429 Crenshaw Blvd., Suite D, Gardena, CA 90249
Tel: 310-679-7624 Fax: 310-679-6346

PHYSICIAN'S HEALTH ASSESSMENT

Participant's Name: _____ **Date:** _____
Last First

Gender: ☐ Male ☐ Female DOB: ____/____/____ Age: _____

Address:
Street_____ City_____ State: _____ Zip: _____

Telephone:
Home: ( ) _____-_____ Cell/Other: ( ) _____-_____

CURRENT PHYSICAL EXAM

Weight: _____ Height: _____ Temp.:_____ P: _____ Resp.:_____ B/P: _____

General:	Lungs:
HEENT:	Heart:
Skin:	Abdomen:
Chest:	Genitourinary:
Neurological:	Musculoskeletal:
Lymphatic:	Extremities:
Significant Medical and Surgical History:	

Diabetic ☐ Yes ☐ No Notify MD if BS > _____ < _____ Check BS: Daily ____ Weekly ____ Monthly ____ Other ____	**HTN** ☐ Yes ☐ No Notify MD if BP > _____ < _____

Allergies	**TB Clearance**	
	PPD Test Date Administered: _____ Date Read: _____ Positive Negative	Chest X-ray Date: _____ Positive Negative

May we have a standing order of:	**Yes**
Mylanta 30 cc po q 4 hours PRN for heartburn, Flatulence and bloating	
Tylenol 650 po q4 hours PRN for pain or temperature <100	
Kaopectate 30 cc po q 4 hours PRN for diarrhea	
Nitroglycerin 0.4 g one tablet SL PRN chest pain; if pain persists repeat 1x in 5 minutes.	
O2, 2-8 liters via n/c or mask, in case of an emergency	
Sliding scale-Regular insulin BS 200-250mg/dl=4 units SQ 251-300mg/dl=6 units SQ 301-350mg/dl=8 units SQ 351-400mg/dl=10 units SQ 401-450mg/dl=12 units SQ BS greater than 450, call MD	

Any **Hospitalization** within the past 12 months? ☐No ☐Yes
Reason for Hospitalization: _____

Assistive Device: (circle all that apply)
Wheelchair **Walker** **Crutches** **Cane** **Prosthesis** **Glasses** **Hearing Aide** **Dentures**

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DIANGOSES	ICD-10 CODE	DIAGNOSES	ICD-10 CODE
Primary:			
Secondary:			

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Can your patient independently self-medicate, including naming all medications, understanding the purpose, time, route, dosage, frequency, and potential side effects? ☐ **Yes** ☐ **No**
If yes, please describe training we should provide to your patient to maintain independence: _____

Prognosis:	
Diet:	☐ Regular (No restrictions) ☐ Diabetic/NCS(No concentrated sugars) ☐Cardiac(Low Na, Low fat & Low cholesterol) ☐ Renal (Low Na, low Potassium, No dairy, Low phosphorus) ☐ Other: **please specify)**

While participant is at El Camino ADHC he/she will be evaluated by the following disciplines, which treatments will you prescribe:

Treatments: Our treatments include the following ---Nursing ---Physical Therapy ---Occupational Therapy ---Social Services ---Dietician ---LCSW (if needed) ---Speech Therapist (if needed)

I approve my patient attending EL Camino ADHC ☐ **Yes** ☐ **No**

TRANSPORTATION

Are there any medical contraindications for transit time to and from ADHC in excess of one hour? (Please note: Normal transit time is one hour or less): ☐ **Yes** ☐ **No**

_____ _____ _____
Physician's Printed Name **Physician's Signature** **Date**

Address

Phone Number **Fax Number**

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Participant Name: _____

I am the primary care physician for the above named patient. I have functioned in this capacity since (date): _____. I have reviewed the medical record of the above named patient. In my professional opinion, I agree that my patient meets all of the following criteria and thus concur with my patient's continuing attendance at El Camino ADHC.

MEDICAL NECESSITY CRITERION #1:
The participant has one or more chronic or post acute medical, cognitive, or mental health condition(s) identified by the participant personal health care provider as requiring monitoring, treatment or intervention, without which the participant's condition(s) will likely deteriorate and require emergency department visits, hospitalizations, or other institutionalizations.

MEDICAL NECESSITY CRITERION #2:
The participant has a condition or conditions resulting in both of the following:

- Limitations in the performance of two or more ADLs and/ or IADLs.

AND

- A need for assistance or supervision in performing ADLs or IADLs as related to the participant's medical, cognitive, or mental health condition or conditions. This assistance or supervision is in addition to any other non-ADHC support the participant is current receiving in place of residence.

ADL's include Ambulation, Bathing, Dressing, Self-Feeding, Toileting and Transferring
IADL's include Access Resources, Housework, Hygiene, Laundry Meal Preparation, Medical Management, and Shopping

MEDICAL NECESSITY CRITERION #3:
The participant's network of non-ADHC supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:

- The participant lives alone and no family or caregivers available to provide sufficient or necessary care or supervision.
- The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient or necessary care or supervision to the participant.
- The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.

MEDICAL NECESSITY CRITERION #4:
A high potential exists for deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalizations or other institutionalization if ADHC services are not provided.
Over the next 6 months.

MEDICAL NECESSITY CRITERION #5:
The participant's conditions require all of the ADHC services set forth in on each day of attendance that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

Printed Name of Care Physician Signature of Primary Care Physician Date

Address and Phone Number of Primary Care Physician

El Camino Adult Day Health Center
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Gardena, CA 90249
(310) 679-7624
(310) 679-6346 (Fax)

ORDER FORM FOR PPD

Date: _____

Ordering Doctor: _____

Address: _____

_____

Phone # _____

This authorization is through a: (please circle) Phone Fax Letter

Participant Name _____

I, _____ MD, authorize El Camino Adult Day Health Care Center to administer a PPD test on the above mentioned participant.

MD signature: _____ Date: _____

PPD TEST

Date Administered: _____ Administered by: _____ Sign: _____
(Print Name and Title)

Date read: _____ Read by: _____