Advanced Adult Day Health Care Center
2315 Kuehner Dr. Suite 121, Simi Valley, CA 93063
TEL: (805) 526-7629 FAX: (805) 864-2664

Admission Form / H & P

****This form must be signed by MD/DO****

Last Name:	First Name:		○Male ○Female
Age:	DOB:	Telephone:	
Current Medical Exam			
General:	Lungs:	Weight:	
H.E.E.N.T:	Heart:	Height:	
Mouth:	Abdomen:	Temperature:	
Thorax:	Genitourinary	HR: (R): (AP):	
Breast:	Musculoskeletal:	Blood Pressure:	
Lymphatic:	Rectal:	History of Seizures: ○Yes ○No	
Please Indicate any of the following:	○Behavioral Symptoms ○Psych Medication ○Communication Deficit ○High Risk of Fall		
Is the patient capable of self-administration of medication? ○Yes ○No			
For mild pain, upset stomach, my patient may be given the following OTC medications at indicated frequency:			
○ E.S. Tylenol (500mg) 1-2 tablets 4-6 hours PRN ○ Mylanta 15cc every 4 hours PRN GI upset ○ Topical antibiotic ointment PRN superficial cuts and abrasions ○ Pepto Bismol 30cc Q 6 min PRN diarrhea ○ O_2 PRN			
Diet: ○Regular ○Puree ○No salt added (2500-4500mgm NA) ○Diabetic ○Liberal Diabetic ○Other _____			
Is nutritional counseling recommended? ○Yes ○No			
Ambulation: ○Ambulatory ○Non-Ambulatory ○Ambulates with Assistance ○No Device ○Cane ○Quad Cane ○Walker ○Wheelchair ○Other			
Special Orders			
All participants attending Advanced ADHC are monitored by RN who will notify PCP of any significant changes			
Indicate the ranges you wich to be notified:			
○ Blood Sugar < 60 and > 300	BS: ○Daily ○Weekly ○Monthly ○PRN		
○ Blood Pressure < 90/50 and > 180/100	BP: ○Daily ○Weekly ○Monthly ○PRN		
Therapy Evaluation (Maintenance Only): ○Physical Therapy ○Occupational Therapy			
Can patient be in a vehicle for transport to the center longer than one hour? ○Yes ○No			

Current Medical Status

Primary Diagnosis:	ICD10 Code:
Secondary Diagnosis:	ICD10 Code:
Additional Diagnosis:	ICD10 Code:
Additional Diagnosis:	ICD10 Code:
Additional Diagnosis:	ICD10 Code:

**********Please attach a printout of any additional diagnoses and health issues**********

Current Medications

Medication	Dosage	Frequency	Indication

**********Please attach a printout of any additional current medications**********

PPD Test Date (Within the last year):	Result:	Last Chest X-Ray Date:	Result:

Any Indication of Communicable Disease? ○Yes ○No

Allergies:

I approve my patient attending Advanced Adult Day Health Care for at least 180 days with my signature below:
(MD or DO Signature only)

Physician's Signature:	Date:
Physician's Full Name:	Specialty:
Phone:	Fax:
Address:	NPI: