Advanced Adult Day Health Care Center
2315 Kuehner Dr. Suite 121, Simi Valley, CA 93063
TEL: (805) 526-7631 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**************

Last PPD Test Date:	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:

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