Rancho Cordova
Adult Day Health Care Center
10086 Mills Station Road
Sacramento, CA 95827
Phone: (916) 369-3730 Fax: (916) 369-1138

INTAKE/EMERGENCY INFORMATION

☐Assess for elopement risk

Participant Name: ____________________________________ **Date**: ________________________
Address: ____
____ MediCal #: ___________________
Phone #: ____ Soc Sec #: ____________________
Date of Birth: ________________ **Age**: __________ **Sex**: F M Days Wanted: _________________

Language: ☐ **Arabic** ☐ **English** ☐ **Farsi** ☐ **Spanish** ☐ **Other:**_________________________________

Emergency Contact: ________________________________ **Phone #**: ____________________________
Address: ____ Relationship:__________________________
Emergency Contact: _______________________________ **Phone#**: ____________________________
Address: ____ Relationship:__________________________
Primary Care Physician: ____________________________
Address**:** ____ Medical Diagnoses:
____ ____________________________________
Phone: ____ ____________________________________
Fax: ____

Medications Listed On Back

Other Medical Specialist(s):
Name ____ **Phone:** ____________________________
Name: ____ **Phone:** ____________________________

Psychiatrist: _____________________________________ Psychiatric Diagnoses: ________________
Phone: ____ ____________________________________
Fax: ____ ____________________________________

Mobility
☐ Ambulatory
☐ Non Ambulatory
☐ Limited
☐ Hx of Falls
☐ Hx of Dizziness

Must Use
☐ Cane
☐ Wheelchair
☐ Walker
☐ Wander Risk

Hx Violence
☐ against self
☐ against others

Other
☐ Blind
☐ Limited Vision
☐ HTN
☐ Dementia
☐ Confusion
☐ Cognitive Deficits

Hearing
☐ Good
☐ Limited
R L
☐ Deaf
R L
☐ Aide(s)
R L

Incontinence
☐ Bladder
☐ Bowel
☐ Briefs

Assistance
☐ Transfer
☐ Toileting

Meals
☐ Diabetic
☐ Needs to be fed
☐ Needs Pureed
☐ Needs Cut Up
☐ Assist Cutting Food
☐ Hx of Choking

I often feel (*CIRCLE ONE*): **Happy Sad Lonely Afraid Angry Other**___________________________

Participant wants to attend Adult Day Health Care because: ______________________________________
____

Person lives: ___alone ___with others (specify number and relationship) ________________________
Person has: ___no caregivers ___family/roommates unwilling or unable to give care/supervision
Person: ___has family/caregivers who need respite to continue care/supervision

Within the last 6 months, person has received these non-institutional services:
___none ___home health ___hospice ___urgent care ___mental health services ___emergency dept.
___other if yes, explain: ____

If currently receiving Home Health or Hospice, specify service and frequency: ______________________
Recent Hospitalization: WHEN? _________ WHERE? ________________ WHAT? ________________

Caregiver? (Y/N): ____ If IHSS, # of Hours: ______ If transfer, name of ADHC______________

My medicines are:

DRUG: _________________________ my dose is________ MG; I take them________ TIMES/DAY

DRUG: _________________________ my dose is________ MG; I take them________ TIMES/DAY

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DRUG: _________________________ my dose is________ MG; I take them________ TIMES/DAY

PHARMACY: ____________________________ PHARMACY: ____________________________

Person who picks up my medications: _________________________ ALLERGIES: ________________

INTAKE COORDINATOR'S NOTES:

____
____
____
____
____

REFFERAL SOURCE: ____

Completed By: ____ **Date:** _______________

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CONSENT TO RELEASE MEDICAL RECORDS

Participant's Name: ___________________________________ Date: ______________

Social Security Number: _____________________________ Date of Birth: __________

Address/Phone Number: ____

____

I hereby request that copies of my complete medical records be released to *Rancho Cordova Adult Day Health Care Center*. I understand that Rancho Cordova ADHC may need to obtain the below checked records and related information from physicians and other healthcare professionals in order to ensure continuity of care and proper reimbursement. I also authorize Rancho Cordova ADHC to release medical record and other information to others for purposes of my healthcare. A photocopy of this authorization shall be as valid as the original.

______ Medical ______ Psychological/Psychiatric _______ Neurological

Participant's Signature: ________________________________ Date: ______________

Participant's Representative/Relationship: _____________________________________

Doctor's Name: ____

Address: ____

Phone/Fax Number: ____

PATIENT HISTORY AND PHYSICAL for ADULT DAY HEALTH CARE / CBAS

Center Name: Rancho Cordova Adult Day Health Care Center____ Address: 10086 Mills Station Rd., Sacramento, CA 95827

Center Phone: (916) 369-1113 ____________________________ Center Fax: (916) 369-1138 ________________________

Patient Name: ______________________________________ M [ ] F [ ] DOB: _____ /_____/_____Exam Date ___/____/___

DIAGNOSES / CONDITIONS reflecting the patient's health status (Complete or attach electronic health record (EHR)

Neuro / Cognitive

☐Alzheimer's disease ☐Cognitive Impairment
☐CVA ☐Dementia
☐Developmentally Disabled ☐Neuropathy
☐Parkinson's ☐Seizures
☐Other:

Cardiovascular

☐Arrhythmia ☐A-fib ☐Anemia ☐Angina
☐CAD ☐CABG ☐CHF
☐HTN ☐MI ☐PVD
☐Other:

Endocrine / Metabolic

Diabetes Mellitus: ☐ (Type 1) ☐ (Type 2)
☐Hyperlipidemia ☐ Hyperthyroidism
☐Hypothyroidism
☐Retinopathy
☐ Other:

Musculoskeletal

☐Chronic Back Pain ☐Joint Replacement
☐Osteoarthritis ☐Osteoporosis
☐Spinal Stenosis
☐Other:

Pulmonary / Respiratory

☐Asthma ☐ Chronic Bronchitis
☐ COPD ☐ Emphysema
☐Other:

Gastrointestinal /Genitourinary

☐Chronic Liver Disease ☐Chronic Kidney Disease
☐GERD ☐Hemorrhoids ☐PUD ☐BPH ☐UTI
☐Other:

Behavioral Health

☐Anxiety ☐Bipolar ☐Depression
☐Schizophrenia ☐Agitation
☐Other:

Other Conditions

☐Cataracts ☐Difficulty Swallowing ☐Insomnia
☐Glaucoma ☐Hearing Loss ☐Low Vision
☐Skin Breakdown
☐Other:

PHYSICAL EXAMINATION (Complete or Attach EHR)

Comments	Comments
HEENT	Gastrointestinal ☐Incontinence Bowel
Respiratory	Genitourinary ☐Incontinence Bladder
Cardiovascular ☐AICD ☐ Pacemaker	Musculoskeletal
Breast / Chest	Integumentary
Neurological	Significant Physical Limitations

Temp: Pulse: Resp Rate: BP : Height: Weight:

TB SCREENING (required by law within last 12 months)
PPD Date:______/_____/______Result:_____________ *OR* CXR Date: __/________/_______Result:
If no TB Screening w/in past 12 months PCP authorizes Center to place PPD. ☐If checked, Center requests PCP to complete PPD and record results.

Allergies *(Medication & Environment):*

Medications: ☐ Possible Mismanagement ☐ Needs Assistance ☐ Needs Supervision ☐ OK to Self-medicate

MEDICATION PROFILE (Complete or Attach EHR)

Medication	Dosage	Route	Freq	Medication	Dosage	Route	Freq
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			

MEDICAL REQUEST FOR ADULT DAY HEALTH CARE / CBAS

Patient Name: ______________________________

1. Unsteady Gait ☐ Yes ☐ No
2. Any known history of falls? ☐ Yes ☐ No
3. Any significant medical history? ☐Yes ☐ No
4. Any known evidence of communicable disease? ☐Yes ☐ No

Travel ☐ Can ☐ Can Not…..be in transit, one way, more than an hour

Please describe any "Yes" answers if details are known:

STANDING ORDERS (PCP, *please strike through any orders not approved and write in alternate orders, as desired)*

Authorization of the following PRN Standing Orders:
Acetaminophen 500 mg 1 - 2 tabs PO PRN every 4 hrs fever ≥ 100 or pain
Not to exceed 3000 mg acetaminophen daily, from all sources
OTC Antacid Name: per package instructions for indigestion
Emergency O2 at 2 or 4 L/min. nasal cannula PRN acute SOB
NTG 0.4 mg SL PRN chest pain: 1 tab every 5 min x 3 doses; Call 911 if not relieved
Kaopectate PO as per package directions PRN diarrhea
MOM 30 cc PRN q 4hrs for constipation
Minor wound protocol cleanse w/ normal saline; apply antibiotic ointment; cover with dry dressing PRN
Tuberculin PPD 0.1 mg ID in forearm Read 48-72 hrs *(if no screen within last 12 mo's)*
Additional or Alternative Orders:

VITAL PARAMETERS	DIET ORDERS
MD may adjust by striking thru and entering desired Parameter(s) for notification.	☐ Regular ☐ No added salt ☐ Low Concentrated Sweets ☐ Other:
Systolic Blood Pressure: 80 - 180 Diastolic Blood Pressure: 50 - 90 Pulse: 50 - 100 Random Blood Glucose: 60 - 250	Center may deviate from low concentrated sweets diet order up to two times a month (special occasions) DIET TEXTURE: ☐ Regular ☐ Chopped ☐ Puréed ☐ Thickened Liquids ☐ Ground ? ☐ Other: Any known food restrictions? ☐ Yes ☐ No Specify:

Note: NIDDM /IDDM RBS weekly/prn symptoms *unless otherwise ordered.* If Insulin administered at center, Daily FBS and prn

Alternative orders:

REQUEST FOR ADULT DAY HEALTH CARE / CBAS SERVICES SECTION (must be completed and signed by PCP)

All patients receive the following on each day of attendance: skilled nursing, social services (PRN), personal care (PRN), therapeutic activities and meal services. Additional services, provided as needed, include physical therapy, occupational therapy, speech therapy, mental health services and transportation, based on multidisciplinary team assessment. ADHC / CBAS services are ongoing unless otherwise indicated.

1. Indicate contraindications for receiving any of the above additional services: ☐ None

   If so, explain______________________________

2. Are there any medical contraindications for one way transportation more than 60 minutes? ☐ None
3. Overall health prognosis? ______________________________
4. Overall therapeutic goals? ______________________________

This patient has one or more chronic or post acute conditions that require monitoring, treatment or intervention, without which there is a high potential for further deterioration and may require emergency room, hospitalization or institutionalization. The information provided reflects this patient's current health status. I request ADHC / CBAS services in addition to authorizing the standing orders.

Print PCP Name: ______________________________

Signature: ______________________________ Date: ______________

PCP Tel: ______________ PCP Fax: ______________ PCP Email: ______________

Rancho Cordova Adult Day Health care Center
10086 Mills Station Road, Sacramento CA 95827
Tel: (916) - 369 - 1113, Fax: (916)-369-3763, Email: intake.rcadhc@gmail.com

Consent form for administering Purified Protein Derivative (P.P.D)

Test for Tuberculosis (TB Test)

I, ____

consent to have Rancho Cordova ADHC nurse Administer and read the P.P.D test for Tuberculosis testing for:

Patient Name: ____________________________________ DOB: ______________

Employee Name: __________________________________ DOB: ______________

Dr. Signature: ____________________________________ Date: _______________

Date P.P.D given: _______________

Lot/Control #: __________________ Expiration: ___________________

Body Location where test applied: _____________________________________

Test given by: ________________________ ___________________________
Signature Title

Print Name: __________________________

Date P.P.D read: _________________

Results: ________________________

Chest X-Ray recommended: ☐ Yes ☐ No (Please check one)

Read By: ________________________ _____________________________
Signature Title

Print Name: ______________________

Please return to Rancho Cordova ADHC:

- This FAX may contain Confidential Information. Per U.S. Federal HIPPA regulations requiring confidentiality, if you have received this FAX in error, please notify us at (916).369.3730.