Adult Life PROGRAMS

Physician Admission Medical Assessment

Participant Name: _____ **Date of Birth:** _____ **Facility**_____

The above named person has applied for enrollment in Adult Life Programs, day supervision for elderly and disabled adults, in a protective setting, approved by the State Department of Health and Human Resources, Division of Aging and Adult Services. Medical information is necessary to ensure appropriate care and provision of services to each individual participant.

Participant health Information is confidential and protected in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

Primary Diagnosis	**ICD -10-CM Code**	NOTES
Diagnosis		
Diagnosis		
Diagnosis		
Diagnosis		
Diagnosis		
Diagnosis		
Diagnosis		
Diagnosis		

** Please attach complete list of Diagnosis and Codes if amount exceeds space.

Allergies: _____

PPD

Most recent PPD Result (if available):	**Date Read :**
Most recent CXR Result (if applicable):	**Date:**

Current Flu Vaccine Status

Flu Vaccine	Date given:	Allergy to Flu Vaccine ☐	Refused ☐

.

Physical Health Status

Vital Signs	Blood Pressure: Pulse:		Respiration: Weight:			
Dentition	Dentures ☐ Partial ☐		Comments:			
Diet	Regular ☐ Soft ☐		Puree ☐ Other:	Thickened liquids ☐ Consistency:	PEG ☐ Tube Feeding ☐	
Vision	Impaired ☐ Glasses ☐ Blindness ☐ Type:		**Hearing**	Hearing Aid ☐ Deaf ☐	**Speech**	Normal ☐ Speech Disorder ☐ Type:
Cardiac:	Pacemaker ☐ Internal Defibrillator ☐		HTN ☐ CVA History ☐	Angina History ☐	Comments	

Adult Life PROGRAMS

Physician Admission Medical Assessment

Participant Name: _____ **Date of Birth:** _____ **Facility**_____

Physical Health Status Continued

Respiratory	Normal ☐ Oxygen ☐ Liter Flow:	Continuous ☐ PRN ☐	Comments:	
Bladder	Continent ☐	Incontinent ☐	Urinary Diversion ☐ Type:	Foley ☐ Condom catheter ☐ Intermittent Self- catheterization ☐
Bowel	Continent ☐	Incontinent ☐	Ostomy ☐ Type:	Constipation ☐
Ambulation	Independent ☐	W/ Assist ☐	Assistive Device ☐ Specify:	Non Ambulatory ☐ Wheelchair ☐
Physical Restrictions	Specify:			
Fall History	Yes ☐ No ☐	History of fall related fracture ☐	Comments:	

Psychiatric or behavior health history? Please describe behavior including selfharm, aggression, wandering or other.

Other comments:

I certify that above named individual is appropriate for participation in Adult Life Programs, Adult Day Care Service.

Sign_____ *Print Name*_____ Date_____
(Licensed Physician, Physician Assistant, Nurse Practitioner)

Office Phone No. _____ **Date Last Seen by MD**:_____