

PHYSICIAN HISTORY AND ORDER FORM

SteppingStone Adult Day Health

- MABINI DAY HEALTH 55 MABINI ST., SF, CA 94107 PH: (415) 882-7301 F: (415) 882-7390
- GOLDEN GATE DAY HEALTH 350 GOLDEN GATE AVE., SF, CA 94102 PH: (415) 359-9210 F: (415) 359-9282
- MISSION CREEK DAY HEALTH 930 FOURTH ST., SF, CA 94158 PH: (415) 974-6784 F: (415) 974-6785
- PRESENTATION DAY HEALTH 301 ELLIS ST., SF, CA 94102 PH: (415) 923-0245 F: (415) 923-0275

PATIENT NAME: _____ DATE: _____
DOB: _____ ADDRESS: _____
PRIMARY DIAGNOSIS: _____

PLEASE CHECK ALL EXISTING DIAGNOSES AND WRITE IN ANY NOT LISTED.

- | | | | |
|--------------------------------|--------------------------|-----------------------|-----------------------|
| _____ Alzheimer's | _____ Cataracts | _____ DM-type I or II | _____ Memory Loss |
| _____ Anemia | _____ CHF | _____ Psychosis | _____ Parkinson's |
| _____ Anxiety | _____ CRF | _____ Dysphagia | _____ PTSD |
| _____ Arthritis | _____ COPD | _____ Emphysema | _____ PVD |
| _____ Asthma | _____ CVA | _____ GERD | _____ Osteoporosis |
| _____ Ataxia _____ R or L Hemi | _____ Gout | _____ Seizures | |
| _____ BPH | _____ Dementia | _____ Hepatitis | _____ Substance Abuse |
| _____ CAD | _____ Depression | _____ HIV | _____ Unsteady |
| _____ DJD | _____ Paranoia _____ HTN | _____ ANY OTHERS? | |

SECONDARY DIAGNOSES: _____

Is client being followed by a psychiatrist or mental health provider? YES ___ (Who? _____) NO ___
If NO, are you the primary provider treating this client's MH problems? YES ___ NO ___

SIGNIFICANT PAST MEDICAL HISTORY _____

PROGNOSIS: _____

CURRENT MEDICATIONS:

	<u>Rx Date</u>	<u>Rx Name</u>	<u>Dose</u>	<u>Route</u>	<u>Freq.</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

MEDICATION ALLERGIES: _____
CAN PATIENT TAKE OWN MEDICATIONS? YES _____ NO _____
DIET: NORMAL _____ SPECIAL TYPE _____

* PLEASE NOTE: All participants are served a meal which complies with the low sodium, low fat, and low cholesterol dietary guidelines.

TB SCREENING or CHEST X-RAY in last 12 MONTHS? (REQUIRED)

_____ Type _____ Date _____ Pos _____ Neg

NURSING SERVICES: These vitals will be performed weekly unless otherwise indicated.

Vital Signs: _____ call MD if SBP> _____, < _____, PR> _____, < _____

Serum Glucose: _____ call MD if RBS> _____, < _____

P.T./O.T./SPEECH: We will provide restorative and/or maintenance physical, occupational and speech therapy, as needed, according to assessments by our licensed professionals (no extra cost) unless you specifically indicate a contra-indication below.

CONTRA-INDICATION FOR THERAPY: _____

ADDITIONAL INSTRUCTIONS, RESTRICTIONS: _____

ADVANCE DIRECTIVES (DNR, DPA) HAVE BEEN COMPLETED?

YES _____ (**Please send copy**) NO _____

Are there any contraindications if your patient were to remain on our bus for more than one hour?

YES _____ NO _____

PREFERRED HOSPITAL IN CASE OF EMERGENCY:

(If no hospital is named, patient will be sent to SF General Hospital for emergency care.)

MAY WE HAVE STANDING ORDERS FOR:

TB Screening (*if not done within last 12 mo*)

YES _____ NO _____

ASA 325 mg I-II P.O. q 4 hrs prn pain

YES _____ NO _____

Tylenol 325 mg I-II P.O. q 4 hrs prn pain

YES _____ NO _____

Maalox 30 cc q 6 hrs prn gastric discomfort

YES _____ NO _____

M.O.M. 30 cc prn constipation q 3 days

YES _____ NO _____

Kaopectate 2 Tbsps q 4 hrs prn diarrhea

YES _____ NO _____

Robitussin I-II tsp. q 4hrs prn cough

YES _____ NO _____

Flu vaccine

YES _____ NO _____

If indicated, may a podiatrist be recommended?

YES _____ NO _____

If indicated, may a dental hygienist be recommended? YES _____ NO _____

Patient's most recent visit to MD? DATE _____

(* Please attach most recent history + physical)

I authorize my patient, _____, to attend ADHC.

MD SIGNATURE _____ DATE _____

PLEASE PRINT NAME: _____

PLEASE FAX TO THE ADHC CHECKED ABOVE TO BEGIN THE INTAKE PROCESS.