

GOLDEN CASTLE ADULT DAY HEALTH CENTER

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(To be completed by the patient/patient's legal representative)

I hereby authorize the release of medical information contained in this report to the facility named above.

Signature of Patient/Legal Representative Date (____) Telephone

Patient Name: _____ Birth Date: ___/___/19____ Sex: M F

Home Address: _____

NOTE TO PHYSICIAN

IF ELECTRONIC HEALTH RECORD (EHR) IS AVAILABLE , PLEASE ATTACH A COPY OF THE LAST VISIT NOTE, THAN COMPLETE AND SIGN PAGE 2 ONLY. IF EHR IS NOT AVAILABLE PLEASE COMPLETE BOTH PAGES.

DIAGNOSES / CONDITIONS reflecting the patient's health status: *Last Exam Date:* ___/___/___

<p>Neuro / Cognitive</p> <p><input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Dementia <input type="checkbox"/> Cognitive Impairment</p> <p><input type="checkbox"/> CVA <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Aphasia <input type="checkbox"/> Ataxia</p> <p><input type="checkbox"/> Other: _____</p>	<p>Cardiovascular</p> <p><input type="checkbox"/> Arrhythmia <input type="checkbox"/> A-fib <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Atherosclerosis</p> <p><input type="checkbox"/> CAD <input type="checkbox"/> CABG <input type="checkbox"/> CHF <input type="checkbox"/> Pulmonary heart disease</p> <p><input type="checkbox"/> HTN <input type="checkbox"/> MI <input type="checkbox"/> PVD <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Other: _____</p>
<p>Endocrine / Metabolic</p> <p><input type="checkbox"/> Diabetes Mellitus: <input type="checkbox"/> (Type 1) <input type="checkbox"/> (Type 2) with complications: <input type="checkbox"/> Neuropathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Retinopathy</p> <p><input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism</p> <p><input type="checkbox"/> Other: _____</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Chronic Back Pain <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Joint Replacement: _____</p> <p><input type="checkbox"/> Other: _____</p>
<p>Pulmonary / Respiratory</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis</p> <p><input type="checkbox"/> COPD <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Other: _____</p>	<p>Gastrointestinal / Genitourinary</p> <p><input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Chronic Kidney Disease (Stage ____)</p> <p><input type="checkbox"/> GERD <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> PUD <input type="checkbox"/> BPH <input type="checkbox"/> UTI</p> <p><input type="checkbox"/> Incontinent of Bowel <input type="checkbox"/> Incontinent of Bladder</p> <p><input type="checkbox"/> Other: _____</p>
<p>Behavioral Health</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Agitation <input type="checkbox"/> Bipolar</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> PTSD <input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Developmental Delay w/behavioral symptoms</p> <p><input type="checkbox"/> Other: _____</p>	<p>Other Conditions</p> <p><input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Insomnia <input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Low Vision/Blind</p> <p><input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Skin Breakdown</p> <p><input type="checkbox"/> Other: _____</p>

Medication/Dosage	Route/Frequency	Medication/Dosage	Route/Frequency
1.		4.	
2.		5.	
3.		6.	

Patient Name: _____

TB SCREENING (required by law within last 12 months)

PPD Date: ___/___/___ CXR Date: ___/___/___ QuantiFERON TB Test Date: ___/___/___ RESULT:: Negative Positive

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

- Acetaminophen 325 mg 1 tab PO Q4 hrs prn mild pain or 2 tabs PO Q4 hrs prn pain
- Antacid: Mylanta 30cc PO Q4 hours prn dyspepsia
- Emergency O2 at 2 or 4 L/min. nasal cannula prn shortness of breath
- Hypoglycemia:
 - 4 oz of orange juice if Blood Sugar is <70 mg/dl.
 - Re-check Blood Sugar in 15 min and give another 4 oz of orange juice + nutrition snack if blood sugar remains <70 mg/dl.
 - Re-check blood sugar in 15 minutes and notify MD if blood sugar continues to be <70 mg/dl.
- Loperamide 2 mg PO as per package directions prn diarrhea
- Minor wound protocol: cleanse w/ normal saline; apply antibiotic ointment; cover with dry dressing prn skin tears and abrasions
- Annual influenza virus vaccine injection per CDC recommendations (if offered at ADHC/CBAS center)

Additional or Alternative Orders: _____

POLST ON FILE : Yes No

VITAL PARAMETERS NOTIFICATION ORDERS	DIET ORDER
Systolic Blood Pressure: <90 or >180 Diastolic Blood Pressure: <50 or >100 Pule: <50 or >110 Blood Glucose: <60 or >300 Note: Blood Glucose testing will be performed PRN per Center Policy unless otherwise ordered.	<input type="checkbox"/> House Diet (Portion controlled, Carbs: 60-70 g/ meal, Protein: 30 g/meal, NSA, NCS) <input type="checkbox"/> Other _____ **Center may deviate from diet up to 2x month for special occasions** Texture: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Mechanical Soft <input type="checkbox"/> Pureed <input type="checkbox"/> Thickened liquids: <input type="checkbox"/> Nectar-thick <input type="checkbox"/> Honey-thick <input type="checkbox"/> Pudding-thick <input type="checkbox"/> Other: _____
<i>Alternative orders:</i>	Known Allergies: (medication, environmental, food)

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

This patient has one or more chronic or post acute medical, cognitive or mental health 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.

All patients receive the following on each day of attendance: skilled nursing, social services, personal care, therapeutic activities and meal services. Additional services provided as needed, and 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 contraindication for participant to self administer medication: _____ None
2. Indicate contraindications for receiving any of the above services: _____ None
3. Are there any medical contraindications for one-way transportation more than 60 minutes: _____ None

*****The information provided reflects the patient's current health status. I request ADHC/CBAS services in addition to authorizing the standing orders.*****

Signature: _____

Date: _____

Print PCP Name: _____

Address: _____

Phone: _____

Fax: _____