GOLDEN CASTLE ADULT DAY HEALTH CENTER
1137 San Antonio Road, Suite B, Palo Alto, CA 94303 Telephone (650) 964-1964 ext. 221 Facsimile (650) 964-1978
Email: info@goldencastlecenter.org ~ Web: goldencastlecenter.org

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION **(To be completed by the patient/patient's responsible person)**
I hereby authorize 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

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: ___/___/___***

Neuro / Cognitive □ Alzheimer's disease □ Dementia □Cognitive Impairment □ CVA □ Neuropathy □ Parkinson's □ Seizures □ Aphasia □ Ataxia □ 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 □ Neuropathy □ Nephropathy □ Retinopathy □ Other:	**Musculoskeletal** □ Chronic Back Pain □ Joint Replacement □ Osteoarthritis □ Osteoporosis □ Spinal Stenosis □ Gout □ 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 □ Agitation □ Bipolar □ Depression □ PTSD □ Schizophrenia □ Other:	**Other Conditions** □ Cataracts □ Difficulty Swallowing □ Insomnia □ Glaucoma □ Hearing Loss □ Low Vision □ Skin Breakdown □ Other:

Medication/Dosage	Route/Frequency	Medication/Dosage	Route/Frequency
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Patient Name: _____

TB SCREENING (required by law within last 12 months)
PPD Date: ___/___/___ or CXR Date: ___/___/___ Result: □Negative □Positive □ PCP authorizes Center to place PPD (if there is no TB Screening within the past 12 months).

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
- 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
- Tuberculin PPD 0.1 mg ID in forearm Read 48-72 hrs
- 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: <80 or >170 Diastolic Blood Pressure: <50 or >110 Pule: <50 or >110 Blood Glucose: <60 or >300 **Note: NIDDM RBS monthly/IDDM RBS weekly/prn symptoms unless otherwise ordered.**	□ Regular □ No Salt Added □ Liberal Diabetic □ Other _____ ***Center may deviate from diet up to 2x month for special occasions**2* Texture: □ Regular □ Chopped □ Pureed □ Thickened liquids □ Other: _____
Alternative orders:	**Allergies:**

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

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.

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 contraindications for receiving any of the above services: _____☐ None
2. Are there any medical contraindications for one-way transportation more than 60 minutes: _____ ☐ None

*****The information provided reflects 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: _____**