

Immaculate Mary Home
Medical Evaluation for Adult Day Program

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

Address: _____
 Street City State Zip Code

Brief HPI: _____

Advance Directives: yes No

HEALTH HISTORY

Past history

Stroke yes no Dates _____
 Diabetes yes no Dates _____
 TB yes no Dates _____
 Heart Disease yes no Dates _____
 Mental Illness yes no Dates _____
 Other yes no Dates _____
 _____ Dates _____
 _____ Dates _____

Sensory Aids: Glasses yes no
 Hearing Aid yes no

Allergies or Drug Sensitivities yes no
 If yes, list: _____

Hospitalization in past 3 months: yes no
 Reason: _____

COMMUNICABLE DISEASE

1. **Is patient free of communicable disease/infection?** yes no
 If communicable disease present, what precautions must be taken to prevent spread in-group setting?

2. **TST (Tuberculin skin test – PPD) - Mandatory**
 Date given: _____ Date Read _____
 Results: _____ If positive provide copy of recent Chest X-Ray.

3. **Vaccinations:**
 Pneumovax: No Yes Date: _____ Influenza: No Yes Date: _____

Functional Status: (Circle one level for each item below)

	Level 1	Level 2	Level 3	Level 4
Eating	Self	With assist	Total care	
Bathing	Self	With Assist	Total care	
Dressing	Self	With Assist	Total care	
Urination	Continent	Occas. Incontinent	Incontinent	Catheter
Defecation	Continent	Occas. Incontinent	Incontinent	Colostomy
Mentation	Clear	Occas. Confused	Confused	
Noisy	Never	Occasionally	Most of time	
Agitation	Never	Occasionally	Most of time	
Depression	Never	Occasionally	Most of time	
Combative	Never	Occasionally	Most of time	
Withdrawn	Never	Occasionally	Most of time	
Wanders	Never	Occasionally	Most of time	
Suicidal	Never	Occasionally	Most of time	
Mobility	Ambulatory	Cane/Walker	Wheelchair	Chair bound
Sight	Not impaired	Impaired	Blind	
Hearing	Not impaired	Impaired	Deaf	
Speech	Not impaired	Impaired	Aphasia	

Activity Permitted Full Limitations /Specify: _____

Participant is capable of administering his/her own medications:
 Self _____ Under Supervision _____ No _____

Comment: _____

Physical Exam:

Date of Physical Exam: _____

Height _____ Weight _____ BP _____ Pulse _____ RR _____ Temp _____

Eyes	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Ears	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Nose	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Throat	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Mouth	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Neck	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Breasts	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Heart	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Lungs	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Abdomen	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Back & Spine	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Neurologic	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Extremities	<input type="checkbox"/> WNL	<input type="checkbox"/> Other	_____
Skin	WNL	<input type="checkbox"/> Other	_____

Diagnosis

Physician Orders:

Diet: No Restrictions No Added Salt No concentrated Sweets
 Other – Specify: _____

Medications:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Routine Orders: Approve by placing an "X" in box for each Rx.

- Fever or Pain - Acetaminophen 325mg – 2 tabs PRN q 4hr,
NOTIFY physician for temperature over 100° or no pain relief.
- Dyspepsia - Mylanta or Maalox – 2 TBSP PO PRN Repeat q ½ hr x 3 doses,
Call physician if no symptom relief
- Diarrhea - Clear liquids, Imodium AD 4mg (20cc), after first episode.
After subsequent episodes – call physician.

Use of Medical Treatments or Therapies? Yes No
 Is there medical information pertinent to diagnosis and treatment in case of emergency? Yes No
 If yes, please describe _____

Physician Name: _____

Address _____
street city state zip code

Telephone Number: _____ Fax Number: _____

Signature _____

Date of Signature _____