Gurwin Adult Day Health Program

68 Hauppauge Road, Commack, NY 11725
631/715-2520 FAX 631/715-2915

PHYSICIAN'S PRE-ADMISSION MEDICAL REPORT/ORDERS

PATIENT'S NAME ______________________ AGE ____________ SEX ________

HOME ADDRESS ______________________________ PHONE (____) ____-________

If Not Presently at Home ______________________________________
Name of Hospital or Nursing Home

1. **DIAGNOSIS** (Specific Diagnosis Required - Date of Onset)

Primary Medical ______________________________________

Psychiatric ______________________________________

Other ______________________________________

Other ______________________________________

*Patient has been informed of his/her medical condition? [ ] YES [ ] NO

Family/Caregiver has been informed of his/her medical condition? [ ] YES [ ] NO

2. Past Hospitalizations/Surgery (within past 12 month period)

HOSPITAL/DATE(S)	REASON

3. **PHYSICAL EXAMINATION:** Height ________ Weight ________ Blood Pressure _____/_____

Temperature ________ Pulse ________ Respirations ______________

Alert [ ] Confused [ ] Agitated [ ] Depressed [ ]

Impairments: Vision [ ] Hearing [ ] Speech [ ] Dementia [ ]

Special Medical Problems: Wound [ ] Decubitus [ ] Chronic Pains [ ]

Incontinence: Bladder [ ] Bowel [ ]

Medical Findings ______________________________________

____

____

4. **LEVEL OF ACTIVITIES:** FULL [ ] MODERATE [ ] LIMITED [ ]

5. Has Pt received **PNEUMOVAX?** [ ] YES ____/____/____ (*Date*) [ ] NO

TETANUS in past 10 yrs.? [ ] YES ____/____/____ (*Date*) [ ] NO

6. **GURWIN CLINIC/SERVICES** (*see cover sheet to order*)

Clinic Service:	**Indication:**

7. **Routine Services include:** *NURSING, SOCIAL WORK, NUTRITION, T.R., DENTAL, REHAB SCREEN & TRANSPORT*

8. **LABS/**Therapeutic Drug Levels **to be done at Gurwin ADHP *with indication:*** ______________

____

PATIENT NAME: ______________________

9. ALLERGIES: ______________________

10. MEDICATION PROFILE:

Medication	Dose	Route	Frequency	Indications

11. ***Standing Orders At ADHP:***

Pain or Fever ↑ 101°:
[ ] Tylenol 325 mg tabs - 2 tabs po q4h prn
[ ] Tylenol Elixir 160 mg/5ml - 20ml po q4h prn

Minor Skin Tears:
[ ] Bacitracin ung - daily dsg p N/S prn

Constipation: [ ] MOM - 30 ml po once daily prn

Heartburn: [ ] Mylanta - 30ml po once daily prn

12. DIET AT ADHP:

Regular [ ] NAS [ ] Reduced NA [ ] Renal [ ] Lo Fat Modification [ ] No Conc. Sweets [ ]

Mech. Soft (meats) [ ] Chopped [ ] Puree [ ] Blenderized [ ]

13. A **2 Stage PPD** is required for admission to Gurwin ADHP. Please check the appropriate order:

[ ] **Annual** PPD done ____/____/____ Results ________ mm, Give Stage 2 PPD 5 TU/0.1 ml Intradermal at ADHP.

[ ] Give Stage1 PPD 5 TU/0.1 ml Intradermal at ADHP and repeat in 1 to 3 weeks for Stage 2.
If the PPD is Positive or Contraindicated, please provide a report copy of a Chest X-Ray dated within 1 year or order by checking below:
[ ] obtain Chest X-Ray for TB Screen at ADHP.

14. I certify that the Adult Day Health Program level of care is required for the next 180 days.

15. NAME OF PHYSICIAN: ______________________ DATE: ____/____/____
(*please print*)

MD SIGNATURE: ______________________

ADDRESS: ______________________

TELEPHONE: (   ) - ______________________ FAX: (   ) - ______________________

UPIN #: ______________________ **MD LICENSE #:** ______________________

MEDICARE PROVIDER #: ______________________ **MEDICAID PROVIDER #:** ______________________

(for office use only) **UTILIZATION REVIEW**

RN Signature: ______________________ Date: ____/____/____ Next Review Date: ____/____/____