GURWIN ADULT DAY CARE
Gurwin Jewish Nursing & Rehabilitation Center

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 ____/____/____ [ ] NO
Date

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

	Clinic Service:	**Indication:**
6. GURWIN CLINIC/SERVICES *(see cover sheet to order)*		

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: ____/____/____