Sunrise Adult Activity & Health

9525 Wilcrest Drive
Houston, TX 77099
Phone: 832-794-2100 Fax: 281-858-2070

INTAKE/EMERGENCY INFORMATION

Assess for elopement risk

Participant Name: _____ **Date**: _____
Address: _____

MediCal #: _____
Phone #: _____ Soc Sec #: _____
Date of Birth:_____**Age**:_____**Sex**: F M Days Wanted: _____

Language: Arabic English Farsi Spanish Other:_____

Emergency Contact: _____ **Phone #**: _____
Address:_____ Relationship:_____
Emergency Contact: _____ **Phone#**:_____
Address:_____ Relationship:_____
Primary Care Physician: _____
Address**:** _____ Medical Diagnoses:

_____

Phone:_____ _____
Fax: _____

Medications Listed On Back

Other Medical Specialist(s):
Name_____ **Phone:**_____
Name: _____ **Phone:** _____

Psychiatrist:_____ Psychiatric Diagnoses: _____
Phone:_____ _____
Fax:_____ _____

Mobility
- Ambulatory
- Non Ambulatory
- Limited
- Hx of Falls
- Hx of Dizziness

Must Use
- Cane
- Wheelchair
- Walker
- Wander Risk

Hx Violence
- against self
- against others

Other
- Blind
- Limited Vision
- HTN
- Dementia
- Confusion
- Cognitive Deficits

Hearing
- Good
- Limited RL
- Deaf RL
- Aide(s) RL

Incontinence
- Bladder
- Bowel
- Briefs

Assistance
- Transfer
- Toileting

Meals
- Diabetic
- Needs to be fed
- Needs Pureed
- Needs Cut Up
- Assist Cutting Food
- Hx of Choking

I often feel (*CIRCLE ONE*): **Happy Sad Lonely Afraid Angry Other_____**

Participant wants to attend Sunrise Adult Activity & Health because:_____

Person lives:___alone ___with others (specify number and relationship) _____
Person has:____no caregivers____family/roommates unwilling or unable to give care/supervision
Person: ___has family/caregivers who need respite to continue care/supervision

Within the last 6 months, person has received these non-institutional services:
___none____home health____hospice _ urgent care____mental health services____emergency dept.
___other if yes, explain: _____

If currently receiving Home Health or Hospice, specify service and frequency: _____
Recent Hospitalization: WHEN?_____WHERE?_____WHAT? _____

Caregiver? (Y/N): __ If IHSS, # of Hours: _____ If transfer, name of ADHC_____

My medicines are:

DRUG:_____my dose is_____MG; I take them_____TIMES/DAY

DRUG:_____my dose is_____MG; I take them_____TIMES/DAY

DRUG:_____my dose is_____MG; I take them_____TIMES/DAY

DRUG:_____my dose is_____MG; I take them_____TIMES/DAY

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DRUG:_____my dose is_____MG; I take them_____TIMES/DAY

PHARMACY:_____PHARMACY: _____

Person who picks up my medications:_____ALLERGIES: _____

INTAKE COORDINATOR'S NOTES:

REFFERAL SOURCE:

Completed By:_____Date: _____

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Consent to release medical records

Participant's Name:_____ Date: _____

Social Security Number:_____Date of Birth: _____

Address/Phone Number: _____

I hereby request that copies of my complete medical records be released to *Sunrise Adult Activity & Health*. I understand that Sunrise Adult Activity & Health may need to obtain the below checked records and related information from physicians and other healthcare professionals in order to ensure continuity of care and proper reimbursement. I also authorize Sunrise Adult Activity & Health to release medical record and other information to others for purposes of my healthcare. A photocopy of this authorization shall be as valid as the original.

_____Medical _____Psychological/Psychiatric _____Neurological

Participant's Signature:_____ Date: _____

Participant's Representative/Relationship: _____

Doctor's Name: _____

Address: _____

Phone/Fax Number: _____

PATIENT HISTORY AND PHYSICAL for ADULT DAY HEALTHCARE/CBAS

Center Name: Sunrise Adult Activity & Health Address: 9525 Wilcrest Drive, Houston, TX 77099

Center Phone: 832-794-2100 Center Fax: 281-858-2070

Patient Name:_____M [ ] F [ ] DOB:__/____/____Exam Date_/___/___

DIAGNOSES / CONDITIONS reflecting the patient's health status **(Complete or attach electronic health record (EHR)**

Neuro / Cognitive
Alzheimer's disease CVA Developmentally Disabled Parkinson's Other:
Cognitive Impairment Dementia Neuropathy Seizures

Cardiovascular
Arrhythmia CAD HTN Other:
A-fib CABG MI
Anemia CHF PVD
Angina

Endocrine / Metabolic
Diabetes Mellitus: (Type 1) (Type 2)
Hyperlipidemia Hypothyroidism Retinopathy Other:
Hyperthyroidism

Musculoskeletal
Chronic Back Pain Joint Replacement Osteoporosis Osteoarthritis Spinal Stenosis Other:

Gastrointestinal /Genitourinary
Chronic Liver Disease Chronic Kidney Disease
GERD Hemorrhoids PUD BPH UTI Other:

Pulmonary / Respiratory
Asthma Chronic Bronchitis COPD Emphysema Other:

Other
Conditions Cataracts Glaucoma Skin Breakdown Other:
Difficulty Swallowing Hearing Loss
Insomnia Low Vision

Behavioral Health
Anxiety Schizophrenia Other:
Bipolar Agitation
Depression

PHYSICAL EXAMINATION (Complete or Attach EHR)

	Comments
HEENT	
Respiratory	
Cardiovascular AICD Pacemaker	
Breast / Chest	
Neurological	
Gastrointestinal Incontinence Bowel	
Genitourinary Incontinence Bladder	
Musculoskeletal	
Integumentary	
Significant Physical Limitations	

Temp: **Pulse:** **Resp Rate:** **BP:** **Height:**
Weight: TB SCREENING (required by law within last 12 months)
PPDDate: / / Result: ***OR*** **CXR Date: / / Result:**
If no TB Screening w/in past 12 months PCP authorizes Center to place PPD. If checked, Center requests PCP to complete PPD and record results.

Allergies *(Medication & Environment):*

Medications: Possible **Mismanagement** Needs **Assistance** Needs **Supervision** OK to **Self-medicate**

MEDICATION PROFILE (Complete or Attach EHR)

	Medication	Dosage	Route	Freq		Medication	Dosage	Route	Freq
1.					7.				
2.					8.				
3.					9.				
4.					10.				
5.					11.				

MEDICALREQUESTFORADULTDAYHEALTHCARE/CBAS

Patient Name: _____

1. Unsteady Gait ☐ Yes ☐ No
2. Any known history of falls? ☐ Yes ☐ No
3. Any significant medical history? ☐ Yes ☐ No
4. Any known evidence of communicable disease? ☐ Yes ☐ No

Travel ☐ Can ☐ Can Not ..**beintransit, oneway, morethananhour**

Please describe any "Yes" answers if details are known:

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

Authorization of the following PRN Standing

Orders: Acetaminophen 500 mg 1 - 2 tabs PO PRN every 4 hrs **fever ≥ 100 or pain** Not to exceed 3000 mg acetaminophen daily, from all sources

OTC Antacid Name: per package instructions **for indigestion**

Emergency O2 at 2 or 4 L/min. nasal cannula PRN **acute SOB**

NTG 0.4 mg SL PRN chest pain: 1 tab every 5 min x 3 doses; Call 911 if not relieved

Kaopectate PO as per package directions

PRN **diarrhea MOM 30 cc PRN q 4hrs for constipation**

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 *(if no screen within last 12 mo's)* ☐

Additional or Alternative Orders:

VITAL PARAMETERS

MD may adjust by striking thru and entering Parameter(s) for notification.

Systolic Blood Pressure: 80 - 180

Diastolic Blood Pressure: 50 - 90

Pulse: 50 - 100

Random Blood Glucose: 60 - 250

DIET ORDERS

☐ Regular ☐ Low Concentrated ☐ Other:

Center may deviate from low concentrated sweets diet order up to two times a month (special occasions) ☐

DIET TEXTURE:

Regular Chopped Pureed Thickened Liquids

Ground ? Other:

Any known food restrictions? Yes No Specify:

Note: NIDDM /IDDM RBS weekly/prn symptoms *unless otherwise ordered.* If Insulin administered at center, Daily FBS and prn

Alternative orders:

☐

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

☐

All patients receive the following on each day of attendance: skilled nursing, social services (PRN), personal care (PRN), therapeutic activities and meal services. Additional services, provided as needed, include physical therapy, occupational therapy, speech therapy, mental health services and transportation, based on multidisciplinary team assessment. Sunrise Adult Activity & Health services are ongoing unless otherwise indicated.

1. Indicate contraindications for receiving any of the above additional services: None
   If so, explain _____
2. Are there any medical contraindications for one way transportation more than 60 minutes? None
3. Overall health prognosis? _____
4. Overall therapeutic goals? _____

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. **The information provided reflects this patient's current health status. I request Sunrise Adult Activity & Health services in addition to authorizing the standing orders.**

Print PCP Name:

Signature: Date:

PCPTel: PCPFax: PCP Email:

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Consent form for administering Purified Protein Derivative (P.P.D)

Test for Tuberculosis (TB Test)

I, _____

consent to have Sunrise Adult Activity & Health nurse Administer and read the P.P.D test for
Tuberculosis testing for:

Patient Name:_____DOB: _____

Employee Name:_____DOB: _____

Dr. Signature:_____Date: _____

Date P.P.D given: _____

Lot/Control #:_____ Expiration: _____

Body Location where test applied: _____

Test given by:_____ _____
Signature Title

Print Name: _____

Date P.P.D read: _____

Results: _____

Chest X-Ray recommended: Yes No (Please check one)

Read By: _____ _____
Signature Title

Print Name: _____

Please return to Sunrise Adult Activity & Health:
This FAX may contain Confidential Information. Per U.S. Federal HIPPA regulations requiring confidentiality, if you have received this FAX in error, please notify us at 832-794-2100.