GOLDEN CASTLE ADULT DAY HEALTH CENTER

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

Home Address: ____

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	**Cardiovascular**
◻ Alzheimer's disease ◻ Dementia ◻Cognitive Impairment ◻ CVA ◻ Neuropathy ◻ Parkinson's ◻ Seizures ◻ Aphasia ◻ Ataxia ◻ Other: ______________________	◻ Arrhythmia ◻ A-fib ◻ Anemia ◻ Angina ◻ Atherosclerosis ◻ CAD ◻ CABG ◻ CHF ◻ Pulmonary heart disease ◻ HTN ◻ MI ◻ PVD ◻ Pacemaker ◻ Other: ______________________
Endocrine / Metabolic	**Musculoskeletal**
◻ Diabetes Mellitus: ◻ (Type 1) ◻ (Type 2) with complications: ◻ Neuropathy ◻ Nephropathy ◻ Retinopathy ◻ Hyperlipidemia ◻ Hyperthyroidism ◻ Hypothyroidism ◻ Other:______________________	◻ Chronic Back Pain ◻ Spinal Stenosis ◻ Gout ◻ Osteoarthritis ◻ Osteoporosis ◻ Rheumatoid Arthritis ◻ Joint Replacement: ________________ ◻ Other: ______________________
Pulmonary / Respiratory	**Gastrointestinal / Genitourinary**
◻ Asthma ◻ Chronic Bronchitis ◻ COPD ◻ Emphysema ◻ Other: ______________________	◻ Chronic Liver Disease ◻ Chronic Kidney Disease (Stage ____) ◻ GERD ◻ Hemorrhoids ◻ PUD ◻ BPH ◻ UTI ◻ Incontinent of Bowel ◻ Incontinent of Bladder ◻ Other: ______________________
Behavioral Health	**Other Conditions**
◻ Anxiety ◻ Agitation ◻ Bipolar ◻ Depression ◻ PTSD ◻ Schizophrenia ◻ Developmental Delay w/behavioral symptoms ◻ Other: ______________________	◻ Difficulty Swallowing ◻ Insomnia ◻ Hearing Loss ◻ Cataracts ◻ Glaucoma ◻ Low Vision/Blind ◻ Macular Degeneration ◻ Skin Breakdown ◻ Other: ______________________

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

Patient Name: ____

TB SCREENING (required by law within last 12 months)	COVID-19 VACCINATION
PPD Date: ___/___/___ CXR Date: ___/___/___ QuantiFERON TB Test Date: ___/___/___ RESULT: □ Negative □ Positive	Status: □ Vaccinated (fill in below) □Not Vaccinated Manufacturer: □ Pfizer □Maderna □Janssen Vaccination Date: Dose 1: ___/___/___ Dose 2: ___/___/___ Dose 3:___/___/___ Dose 4:___/___/___

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 shortness of breath
- Hypoglycemia:
  - 4 oz of orange juice if Blood Sugar is <70 mg/dl.
  - Re-check Blood Sugar in 15 min and give another 4 oz of orange juice + nutrition snack if blood sugar remains <70 mg/dl.
  - Re-check blood sugar in 15 minutes and notify MD if blood sugar continues to be <70 mg/dl.
- 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 skin tears and abrasions
- 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: <90 or >180 Diastolic Blood Pressure: <50 or >100 Pule: <50 or >110 Blood Glucose: <60 or >300 **Note: Blood Glucose testing will be performed PRN per Center Policy unless otherwise ordered.**	□ House Diet (Portion controlled, Carbs: 60-70 g/ meal, Protein: 30 g/meal, NSA, NCS) □ Other ______________________ ***Center may deviate from diet up to 2x month for special occasions*** Texture: □ Regular □ Chopped □ Mechanical Soft □ Pureed □ Thickened liquids: □ Nectar-thick □ Honey-thick □ Pudding-thick □ Other: ______________
Alternative orders:	**Known Allergies**: (medication, environmental, food)

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

This patient has one or more chronic or post acute medical, cognitive or mental health 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 contraindication for participant to self administer medication:______________________ ☐ None
2. Indicate contraindications for receiving any of the above services: ______________________ ☐ None
3. Are there any medical contraindications for one-way transportation more than 60 minutes: __________ ☐ None

*****The information provided reflects the 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:** ______________________________