GRACE
Adult Day Health Care

Dear Health Care Professional,

Your patient has applied to join the Grace Adult Day Health Care Center. We want to thank you in advance for your time and referral. We look forward to partner with you to help to care for your patient. We will stay in communication and update you with any change in your patient's mental and physical health condition. We hope the information below gives you a good idea about Grace Adult Day Health Care Services.

The primary objectives of the Program:

The Program stresses partnership with the participant, the family and/or caregiver, the primary care physician, and the community to maintain personal independence.

- Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities
- Delay or prevent inappropriate or personally undesirable institutionalization

Quick program overview:

Grace ADHC is licensed by the California Department of Public Health and certified by the California Department of Aging. Grace ADHC is an approved Community-Based Adult Services (CBAS) provider. Our Program consists of a multidisciplinary team of healthcare professionals who conduct a comprehensive assessment of each participant to determine and plan services needed to meet their specific health and social needs. Services provided at the center include the following:

- Professional Nursing Services
- Physical, Occupational and Speech Therapies
- Mental Health Services
- Therapeutic Activities
- Social Services
- Personal Care
- Hot Meals and Nutritional Counseling
- Door-to-Door transportation for most areas of Santa Clara County

Individuals may be eligible if they have:

- A medical condition that requires treatment or rehabilitative services prescribed by a physician
- A physical and/or mental impairment that handicap activities of daily living, but not so serious as to require 24-hour institutional care
- A reasonable expectation that preventative services will maintain or improve the present level of functioning
- A high chance of further deterioration and probable institutionalization if ADHC services were not available

We always strive to do our best, and your input is of great value. Please do not hesitate to contact us if you wish to discuss any of this information in more depth. We look forward to seeing you at our center when your time allows.

Respectfully,
Grace Adult Day Health care

Adult Day Health Care

PATIENT HISTORY AND PHYSICAL FOR ADULT DAY HEALTH CARE / COMMUNITY BASED ADULT SERVICES

Patient Name: _____ **M ☐ F ☐ DOB:** ___/___/____ **Last Exam Date** ___/___/____

Center Name: Grace ADHC Center Tel: (408) 727-6280 Center Fax: (408) 516-9527

Address: 3010 Olcott St Santa Clara CA 95054-3207

☐ **EHR attached (If EHR is attached, bypass any related sections below)**

Section A. DIAGNOSES / CONDITIONS reflecting the patient's health status

***PRIMARY DIAGNOSIS (REQUIRED):** _____ *** Include ICD-10 Code. Check all that apply below.**

SECONDARY DIAGNOSIS: _____

Central Nervous System Diseases (G00-G99)

☐ Parkinson's disease ☐ Cerebral palsy
☐ Alzheimer's disease ☐ Seizure disorder
☐ TIAs & related syndrome ☐ Cerebrovascular disease
☐ Idiopathic neuropathy ☐ Hydrocephalus
☐ Hemiplegia/hemiparesis

☐ Other nervous system (specify): _____

Diseases of the Circulatory System (I00-I99)

☐ Hypertension ☐ A-fib ☐ MI ☐ Angina
☐ Arrhythmia ☐ PVD ☐ CHF
☐ Pulmonary heart disease ☐ Atherosclerosis

☐ Other circulatory (specify): _____

Endocrine, Nutritional & Metabolic Diseases (E00-E89)

☐ Diabetes Mellitus
☐ (Type 1) ☐ (Type 2) with complications:
☐ Retinopathy ☐ Neuropathy ☐ Nephropathy
☐ Other _____

☐ Hyperlipidemia ☐ Hyperthyroidism
☐ Hypothyroidism ☐ Nutritional Deficiency

☐ Other Metabolic Disorder (specify): _____

Diseases of Musculoskeletal/Connective Tissues (M00-M99)

☐ Rheumatoid Arthritis ☐ Osteoarthritis
☐ Gout ☐ Osteoporosis

☐ Joint replacement _____

☐ Other musculoskeletal disorder (specify): _____

☐ Other connective tissue disorder (specify): _____

Pulmonary / Respiratory Diseases (J00-J99)

☐ Asthma ☐ Chronic Bronchitis
☐ COPD ☐ Emphysema

☐ Other respiratory/pulmonary diseases (specify): _____

Diseases of Digestive (K00-K95) & Genitourinary (N00-N99) Systems

☐ Chronic Liver Disease ☐ BPH
☐ Hemorrhoids ☐ GERD
☐ Liver disease ☐ Peptic Ulcer
☐ Chronic UTI
☐ Chronic Kidney Disease Stage _____

☐ Other digestive & genitourinary (specify): _____

Mental, Behavioral & Neurodevelopmental Disorders (F01-F99)

☐ Anxiety ☐ Bipolar ☐ Depression
☐ Developmental delay w/ behavioral symptoms
☐ Schizophrenia ☐ Agitation
☐ Unspecified dementia (pre-senile, senile, primary degenerative)

☐ Other behavioral & emotional disorder (specify): _____

Other Conditions

☐ Cataracts ☐ Macular degeneration ☐ Insomnia
☐ Glaucoma ☐ Hearing loss ☐ Low vision/blind
☐ Skin breakdown ☐ Ataxia ☐ Aphasia

☐ Other conditions (specify): _____

Patient Name: ’ _____ DOB: ___/____/_____

Section B. CURRENT MEDICATIONS (If EHR is attached, bypass Medication Section below)
(Center will conduct medication reconciliation and report inconsistent findings to MD)

Medication	Dosage	Route	Freq	Medication	Dosage	Route	Freq
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

Section C. PHYSICAL EXAMINATION

Comments	Comments
HEENT	**Gastrointestinal** ☐ Incontinence Bowel
Respiratory	**Genitourinary** ☐ Incontinence Bladder
Cardiovascular ☐ AICD ☐ Pacemaker	**Musculoskeletal**
Breast / Chest	**Integumentary**
Neurological	**Significant Physical Limitations**
All participants must show evidence of tuberculosis screening performed within 1 year prior to CBAS/ADHC start date: **Last PPD Test Date:**_____ ☐**pos.** ☐**neg.** **Last Chest X-Ray Date:**_____**Please attach results** **QuantiFERON Tb test Date:**_____ ☐**pos.** ☐**neg.**	**Date Vitals Taken:**___/___/___ **Weight:**_____ **Height:**_____ **Temperature:**_____ **Blood Pressure:**_____ **Heart Rate/Pulse:**_____

Known Allergies *(medication & environmental):*

Section D. VITAL PARAMETERS AND ORDERS

PCP may adjust by entering alternative parameter range. RN will notify PCP of clinical findings.

Systolic BP	Diastolic BP	Pulse	Random Blood Glucose
Range: 90-160	Range: 60-100	Range: 60-100	Range: 70-300
Alternative Range:	Alternative Range:	Alternative Range:	Alternative Range:

Glucose Testing at Center: ☐ N/A ☐ RBS Daily ☐ RBS Weekly ☐ RBS Monthly ☐ PRN symptoms

☐ Waive RBS readings ☐ Other (please specify):_____

Section E. DIET ORDERS

☐ Regular (no added salt or added fat) ☐ No concentrated sweets (NCS) ☐ Low fat ☐ Other (specify): _____

☐ Regular texture ☐ Chopped ☐ Mechanical soft/finely chopped texture ☐ Pureed texture

☐ Thickened Liquids: ☐ Yes ☐ No If Yes, *consistency:* ☐ Nectar-thick ☐ Honey-thick ☐ Pudding-thick

☐ NPO, G/J-Tube Feedings:_____(formula & amount/day)

Any known food restrictions? ☐ Yes ☐ No Specify:	Any known food allergies? ☐ Yes ☐ No Specify:

Patient Name: ’ DOB: ___/____/_____

Section F. RISK FACTORS

1. Unsteady gait?	☐ Yes ☐ No	4. Recent hospitalization? (w/in 6 mo’s)	☐ Yes ☐ No
2. Hx of falls?	☐ Yes ☐ No	5. Medication mismanagement?	☐ Yes ☐ No
3. Hx of communicable disease?	☐ Yes ☐ No	If No, *is patient able to self-administer at Center?*	☐ Yes ☐ No

Please describe any “Yes” answers, if details are known:

Section G. REQUEST FOR ADHC/ CBAS SERVICES (must be completed and signed by PCP)

All patients receive the following on each day of attendance: skilled nursing, social services and/or personal care, 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. ADHC / CBAS 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 exceeding 60 minutes? ☐ None

If so, specify limitations:

3) Overall health prognosis?

4) Overall therapeutic/treatment goals:

AUTHORIZATION

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 or and may require emergency room, hospitalization or institutionalization level of care. **The information provided reflects this patient’s current health status. I request ADHC / CBAS services in addition to authorizing the attached standing orders.**

Print PCP Name:		
PCP Signature:		Date:
Tel:	Fax:	Email:

Patient Name: ’ _____ DOB: ___/____/_____

PCP STANDING ORDERS: Strike out any standing order that is not authorized

PCP STANDING ORDERS: Strike out any standing order that is not authorized.			
Emergency O2: At 2 - 4 l pm via nasal cannula prn, for shortness of breath; Emergency O2 to maintain O2 Sat ≥ 88%			
Chest Pain/MI: Non-enteric coated ASA 81 mg 2 tabs PO 1x			
Fever: (Most often with headache &/or body pain and other symptoms, please choose one for body temp > 100F) □ Acetaminophen 500 mg 2 tabs PO □ Ibuprofen 200 mg 1 tab PO taken with food			
Diarrhea: Loperamide 2 mg PO as per package directions prn diarrhea			
Constipation: MOM			
Cough: Robitussin 10 ml every 4 hrs.	**Antihistamine:** Benadryl 25 mg1 to 2 tabs 4 to 6 hrs.	**Dry Eyes:** Refresh Plus 1 or 2 drops	**Burns:** Relief Spray (Lidocaine HCl 0.5%)
Hypoglycemia: RBS < 70 □ Soluble glucose tablets 15 g SL & re-check RBS after 15 minutes □ Orange juice + 2 tbsp. regular sugar & re-check RBS after 15 minutes			
Indigestion: OTC: Antacid: Mag – Al Plus XS unit dose per package instructions			
Pain: (please choose one) □ Acetaminophen □ 325 mg 1 tab PO q 4 hrs. for mild pain or 2 tabs PO q 4 hrs. for moderate – severe pain □ 500 mg 1 tab PO q 4 hrs. for mild pain or 2 tabs PO q 4 hrs. for moderate – severe pain □ Ibuprofen taken w/food - 200 mg 1 tab PO q 4 hrs. for mild pain or 2 tabs PO q 4 hrs. for moderate – severe pain □ Asper cream with Lidocaine			
Non-drug pain management: Warm compress to alleviate muscle tissue discomfort. Cold compress for chronic inflammatory conditions or contusions			
Skin Care: Clean incontinent client using pH balanced surfactant followed by drying the skin and apply A&D ointment preventatively. If there is Stage 1 or 2 irritation noted by the CBAS/ADHC licensed nursing staff, a “one time” application of Calmoseptine® ointment (or generic equivalent) will be applied and a nursing assessment conducted followed by treatment order request from the physician.			
Wound care: Minor wound protocol, including skin tears and abrasions - Cleanse with normal saline, apply antibiotic ointment, Neosporin, cover with dry dressing as needed.			

PCP Signature authorizing Standing Orders: _____