



Dear Doctor,

Your patient has applied to join **Grace Adult Day Health Care**, a licensed Community-Based Adult Services (CBAS) center in Santa Clara. Before services can begin, we need your completed History & Physical. Your input helps us create a safe, individualized plan of care, which we will share with you for your review and signature.

CBAS serves adults whose chronic conditions make daily life difficult and who are at risk of losing their independence. Each day, your patient receives nursing care, social services, therapeutic activities, and a hot meal. Other services are arranged based on each participant's assessed needs.

Between office visits, our nurses monitor your patient's health, reconcile their medications, and contact you when something changes, so problems can be addressed early.

WHAT WE NEED FROM YOU

1. Complete and sign the **History & Physical** (pages 1–3).
2. On the **Standing Orders** (page 4), mark **YES or NO** for each order and sign. Orders left blank will not be given.
3. Include **TB screening results** from within the past year.
4. **POLST** (if applicable): include a copy of your patient's POLST, or complete the attached form with your patient.
5. Fax all pages to **(408) 516-9527**.

REMINDER

Every 6 months: We will fax you your patient's **Individual Plan of Care (IPC)**, which outlines the care and services your patient receives at our center. Please sign and fax it back so services can continue.

Questions, or would you like to visit? Call us at **(408) 727-6280**.

Thank you for your time and for trusting us with your patient's care.

Respectfully,
Grace 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.	
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:
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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: _____

PCP STANDING ORDERS

Patient Name: _____ DOB: ____/____/____

Please mark YES or NO for each order. Orders left blank will NOT be given.

ORDER	YES	NO
Emergency O2: At 2–4 L/min 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 (temp > 100°F, most often with headache &/or body pain)		
• Acetaminophen 500 mg 2 tabs PO q6h prn, max 3 g/day	☐	☐
• Ibuprofen 200 mg 1 tab PO taken with food	☐	☐
Diarrhea: Loperamide 2 mg PO as per package directions prn diarrhea	☐	☐
Constipation: MOM 30 ml PO once prn	☐	☐
Cough: Robitussin 10 ml PO q4h prn, max 60 ml/day	☐	☐
Antihistamine: Benadryl 25 mg 1–2 tabs q4–6h prn	☐	☐
Dry Eyes: Refresh Plus 1 or 2 drops	☐	☐
Burns: Relief Spray (Lidocaine HCl 0.5%)	☐	☐
Hypoglycemia (RBS < 70)		
• Soluble glucose tablets 15 g PO (chew) & 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		
• Acetaminophen 325 mg 1 tab PO q 4 hrs. for mild pain or 2 tabs PO q 4 hrs. for moderate–severe pain	☐	☐
• Acetaminophen 500 mg 1 tab PO q 4 hrs. for mild pain or 2 tabs PO q 4 hrs. for moderate–severe pain	☐	☐
• Ibuprofen 200 mg taken with food, 1 tab PO q 4 hrs. for mild pain or 2 tabs PO q 4 hrs. for moderate–severe pain	☐	☐
• Aspercreme 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 Name (print): _____

PCP Signature: _____ Date: _____



EMSA #111 B
(Effective 4/1/2017)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

- Check One**
- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

- Check One**
- ☐ **Full Treatment** – primary goal of prolonging life by all medically effective means.
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
- ☐ **Trial Period of Full Treatment.**
- ☐ **Selective Treatment** – goal of treating medical conditions while avoiding burdensome measures.
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
- ☐ **Request transfer to hospital only if comfort needs cannot be met in current location.**
- ☐ **Comfort-Focused Treatment** – primary goal of maximizing comfort.
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: _____

C ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

- Check One**
- ☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
- ☐ Trial period of artificial nutrition, including feeding tubes. _____
- ☐ No artificial means of nutrition, including feeding tubes. _____

D INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

☐ Advance Directive not available

☐ No Advance Directive

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: (write self if patient)	
Signature: (required)	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**Patient Information**

Name (last, first, middle):	Date of Birth:	Gender: M F
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NP/PA's Supervising Physician

Name:

Preparer Name (if other than signing Physician/NP/PA)

Name/Title:

Phone #:

Additional Contact☐ None

Name:

Relationship to Patient:

Phone #:

Directions for Health Care Provider**Completing POLST**

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED