CONNECTIONS

MEDICAL REPORT/PHYSICAL EXAMINATION

NAME: _____ DOB: _____

PRIMARY DIAGNOSIS: _____ ICD10 Code: _____

SECONDARY DIAGNOSIS: _____

WEIGHT _____ HEIGHT _____ BP _____ HR _____ Resp. _____ Temp._____

VISION SCREENING: _____ HEARING SCREENING: _____

ALLERGIES: _____ DIET/RESTRICTIONS: _____

FALL RISK: LIST ALL PRECAUTIONS: _____

HOSPITALIZATIONS IN THE PAST YEAR (reasons, hospital, dates): _____

_____

A PPD is **required at enrollment and every other year thereafter in order to attend the Inglis Day Program. A chest x-ray is required if the patient's PPD is positive.

TB TEST: Date Placed: _____ Date Read: _____ Results: _____

CXR Date: _____ Results: _____

All patients under age 60 **must have** had the Tetanus/Diphtheria vaccination/booster (Td) within the past 10 years. Please administer as needed. **Tetanus/Diphtheria (Td) Date Placed**: _____

CAPABLE OF ADMINISTERING OWN MEDICATIONS: YES _____ NO _____

Medication	Strength	Dosing/Frequency	Route	Diagnosis

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PHYSICAL EXAMINATION: Check if abnormal & describe.					
Eyes:		Breasts:		Abdomen:	
Ears:		Skin:		Hernia:	
Nose:		Lungs:		Genitalia/Male	
Throat:		Heart:		Gynecological:	
Mouth:		Arteries:		Anal/Rectal:	
Neck:		Veins:		Nervous System:	
Describe, if applicable:					

Describe Aids/Assistive Devices Used, if applicable:

FUNCTIONAL LEVEL

Eating: Self _____ Assist _____ Total Assist _____ Tube Fed _____

ADL's: Self _____ Assist _____ Total Assist _____

Continence (Urine): Continent _____Incontinent:_____

Continence (Bowel): Continent _____ Incontinent:_____

Mobility: Ambulatory _____ Cane/Walker _____ Wheelchair _____

Speech: Unimpaired _____ Mild Difficulty _____ Aphasic _____

Memory: Intact _____ Impaired Short Term _____ Impaired Long Term _____

Mental Status: Clear _____ Occasionally Confused _____ Confused _____

Mental Health History _____ please explain _____

Assessment of health maintenance needs, medication regimen, and need for blood work: _____

_____

I HAVE EXAMINED THE ABOVE INDIVIDUAL ON (Date) _____ AND FIND HIM/HER TO BE IN GOOD HEALTH AND FREE FROM COMMUNICABLE DISEASEs/INFECTIONS. As part of my exam, I have reviewed pertinent medical history.

IF NOT FREE OF COMMUNICABLE DISEASE, PLEASE GIVE SPECIAL PRECAUTIONS TO ENSURE SAFETY OF OTHER ADULT DAY PARTICIPANTS AND STAFF: _____

_____

_____ _____ _____

Physician/CRNP Name & NPI# Physician/CRNP Signature Date

_____

Address of Physician/CRNP

_____ _____

Physician/CRNP Phone # Physician/CRNP Fax #

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PRESCRIBED DIET

Assistance Needed	❑ None	❑ Assist with set up	❑ Total Assistance	❑ Tube fed	❑ NPO
DIET LEVEL	❑ Regular Diet: no choking or aspiration risks	❑ Soft Diet: Food is of soft/moist consistency	❑ Mechanically chopped/ground: food processor is used, crumbly & moist consistency	❑ Pureed, Pudding-like	❑ NPO (nothing by mouth)
LIQUID consistencies	❑ Thin/ Regular	❑ Nectar-like	❑ Honey-like		
Food Allergies/ Foods to Avoid:					
Special Precautions related to Diet:					

SEZUIRE PROTOCALS

Does this person have a seizure Diagnosis? ❑ Yes ❑ No
Prescribed protocol if a seizure occurs:
Are you prescribing PRN seizure medications? ❑ Yes ❑ No If Yes, please describe:

MEDICAL EMERGENCY NEEDS

Is there any information pertinent to diagnosis in case of a medical emergency? ❑ Yes ❑ No If Yes, please describe:

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