INGLIS DAY PROGRAM
2600 Belmont Avenue, Philadelphia, PA 19131-2799
Phone: 215.581.0736 Fax: 215.878.6920

MEDICAL REPORT/PHYSICAL EXAMINATION

NAME: _____ DOB: _____

PRIMARY DIAGNOSIS:_____

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

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:					

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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.

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

_____

_____ _____ _____

Physician/CRNP Name Printed Physician/CRNP Signature Date

_____

Address of Physician/CRNP

_____ _____

Physician/CRNP Phone # Physician/CRNP Fax #

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PRESCRIBED DIET CONSISTENCIES/TEXTURES

NAME: _____ DOB: _____
PRIMARY DIAGNOSIS: _____

Assistance Needed: ☐ Self ☐ Assist with set up ☐ Total Assistance ☐ Tube fed

Diet: ☐ NPO (nothing by mouth) ☐ House/Regular ☐ Diabetic
☐ Recreational Feedings Only (g-tube diet- only pleasure feed by mouth)

Diet Type: ☐ Low Fat ☐ Low Cholesterol ☐Low Triglycerides
☐ Low Salt ☐ High Fiber ☐ Other, please list: _____

Food Consistencies:
☐ Regular Diet: individual is able to cut their own food, no choking or aspiration risks
☐ Regular Diet: staff must cut food prior to serving due to individual's inability to cut food, no choking or aspiration risks
☐Soft Diet: Food is of soft/moist consistency, requiring some chewing, may add liquid to moisten
☐ Mechanically chopped/ground: food processor is used, check to ensure no chunks, crumbly/moist consistency, may add liquid to moisten
☐ Pureed, Pudding-like: food processor used, smooth, pudding-like, very moist consistency, ensure no chunks, strainer can be used, likely need to add liquid to moisten

Liquid Consistencies:
☐ Thin/Regular Consistency
☐ Nectar-like Consistency
☐ Honey-like Consistency

Fluid Restrictions:
☐ Yes, _____ ccs/24 hours
☐ No

Aspiration Precautions: ☐ Yes, please note specific instructions: _____
☐ No

Food Allergies: _____

_____