

PHYSICAL EVALUATION / ORDERS For Adult Day Health Care Services

Patient Name Medicaid ID

Date of Birth Age Date of Examination

Physician’s Name NPI#

Physician’s Address

City, State, Zip Code Phone

Vital Signs: BP P R T

**Tuberculosis Screening:**

2-Step Skin Test: Yes Date 1st step: Result:

Within past 12 mos. Date 2nd step: Result:

 Quantiferon Gold Date Drawn: Result:

Chest X-Ray (**Only if patient has documented history of Positive Skin Test**): Yes Date:

 Results:

 **\*\*\*PLEASE PROVIDE A COPY OF THE TB OR CXR REPORTS\*\*\***

**COVID-19 Screening: Ray of Sunshine requires all new enrollees be tested prior to start of services.**

Please indicate if patient/individual has any of the following symptoms:

 Fever or Chills Sore throat

 Cough New Loss of taste of smell

 Shortness of breath or difficulty breathing Congestion or runny nose

 Fatigue Nausea or vomiting

 Muscle or Body Aches Diarrhea

 Headache

Date Test was done: Date Received Results: Results:

Does this patient have any infectious diseases? Yes No

If Yes, please specify:
**Diagnoses/ICD-10 Codes:**

1. 4.
2. 5.
3. 6.

Is patient taking any Medications? Yes No If a current list of medications is available,

please attach to this

Please indicate which are to be given at Ray of Sunshine

|  |  |  |
| --- | --- | --- |
| **Name of Medications** | **Dosage / Route / Frequency** | **Give at Ray of Sunshine** (Yes/No) |
|  |  |  |
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May have the following if necessary: Tylenol 500mg 1-2 tabs q4-6hrs prn pain Antacid 30cc prn gastric discomfort

 (May give Antacid chewables (TUMS) in lieu of liquid form)

**Describe individual’s current:**

**Cognitive impairments or limitations at time of exam** None Memory Impairment

 Psychological Social Behavior

**Physical Impairments or limitations at time of exam** None Assist w/ ambulation

 Assist w/ transfers Needs assistive device (cane, walker, wheelchair/scooter)

Visual impairment Hearing impairment Speech impairment Has prosthesis

**Nutritional Status**

Excellent Good Fair Poor

Nutritional Needs/Special Diet: None Regular Special (please specify below) Pureed

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*If meal substitution for medical reasons is indicated, will require a separate for to be filled out**

**Allergies:**  NKA Food Medication

Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History and Physical** (Please attach a dictated/Electronic H&P for the last 6 months)

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medicaid ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_