



Welcome to our family.

ADULT DAY HEALTH CARE 525 Audubon Avenue, NY, NY 10040 (212) 342-9813
PHYSICIAN ADMISSION MEDICAL ASSESSMENT

Patient's Name: (LAST) (FIRST) Sex: (M.I.)
Patient's Home Address: (STREET/APT #) (CITY) (STATE) (ZIP CODE) (PHONE)
Age: Date of Birth: Date of Exam:

Diagnosis: Primary/Date of: Secondary:
Medications (include dose, route & frequency):

PPD Result: Date Given:
CXR Result: Date:

Current Mental Status (Including orientation, Psych. Dx, etc.):
Vital Signs: HT WT BP T P R
Allergies:
Treatments: (include glucose testing, frequency, parameters and sliding scale):
Standing Orders (please (✓) applicable orders)
Tylenol 325 MG. TABS ii P.O. Q4H PRN Pain/Fever (101)
Maalox 30 CC P.O. Q4H PRN For Ingestion
Kaopectate 30 CC P.O. Q4H For Diarrhea
N.T.G. 1/150 gr i Sub Lingual PRN For Chest Pain (Repeat Q 5 minutes for 15 minutes)
PRN O2

Table with columns: Functional Status, Independent, W/Assist, Unable, Assistance Devices (Specify). Rows include Ambulation, Transfers, Feeding, Toileting, W/C Propulsion, Bowel, Bladder, Hx of Falls, Hx of Wandering Behavior.

Recommendation For Rehab: PT-Eval. & Tx. (reason)
OT -Eval. & Tx. (reason)
Speech -Eval. & Tx. (reason)
(Please attach specifics regarding rehab recommendations):
Any Restriction On Physical Activity: Yes No If Yes Explain:
Refer to Isabella Clinics prn (eg. Podiatry)

DIET: Regular NCS (No Concentrated Sweets) Diet Renal Diet NAS (No Added Salt Diet)
DATE HGB HCT WCB PLT GLU K+ NA+ CL- BUN CREAT

EKG: OTHER SIGNIFICANT LABS: Cholesterol, etc.

I certify that the above named patient is medically appropriate for participation in Isabella Adult Day Health Care Program. S/he is free from the infections state of any communicable disease. Because of the anticipated benefits, I prescribe this program for him/her.

I am aware of and in agreement with this referral for medical day care and recognize that the above named patient needs at least 30 days of care and services.

M.D. NAME (PRINT) SIGNATURE
ADDRESS PHONE NUMBER (EXTENSION)
DATE LICENSE #
M.D.'S FAX NUMBER HOSPITAL / CLINIC

PLEASE FAX TO: (212) 342-9805