GOLDEN LIFE ADULT DAY HEALTH CARE CENTER

9158 Fletcher Parkway, La Mesa, CA 91942-3449
Work Phone (619) 357-7753 - Fax Number (619) 439-6038

MEDICAL INFORMATION / AUTHORIZATION REQUEST/PHYSICAL EXAM (Page 1 of 2)

Name: **DOB:** Male ☐ Female ☐

SS #: **Address:** **Phone:**

Please enclose copy of most recent MD notes.

List all Diagnosis Primary:

Secondary:

Allergies:

Prognosis: (Circle one) ☐ Good ☐ Fair ☐ Poor

Is there any evidence of infectious disease? No ☐

Explain:

All Participants in CBAS program must show evidence of Tuberculosis screening in the last 12 months.

Date of last P.P.D: **OR**

Results: Positive ☐ Negative ☐

Date of Chest X-ray:

Results: Positive ☐ Negative for TB ☐

Please circle Yes if any history or diagnosis present:

History of Seizures	Yes No	History of Chest Pain	Yes No
History of falls	Yes No	Diagnosis of Dementia	Yes No
High Blood Pressure(hypertension)	Yes No	Memory Impairment	Yes No
Cardiovascular disease	Yes No	Cognitive Impairment	Yes No
COPD/Pulmonary disease	Yes No	Depression/Anxiety/PTSD	Yes No
Visual Impairment	Yes No	Endocrine/Metabolic	Yes No
Hearing Impairment	Yes No	Musculoskeletal (arthritis)	Yes No
		Other:	

Current Medications:	Dosage	Frequency	Current Medications:	Dosage	Frequency

May we administer the following Medications:

Tylenol or equiv.650 mg q4h prn pain Yes ☐ No ☐

Mylanta or equiv.30cc q4h prn dyspepsia Yes ☐ No ☐

Nitroglycerin .4mg SL q 5min x3tab prn for chest pain Yes ☐ No ☐

May we do blood glucose testing on this patient with/without have a medical diagnosis that would require testing of blood glucose? Yes ☐ No ☐

~~Contact MD if blood pressure is greater than 160/90 or~~ less than 90/50 Yes ☐ No ☐

Contact MD if blood glucose is greater than 250 mg/dL or less then 70 mg/dL Yes ☐ No ☐

May this participant self-administer the above medications while at our Center Yes ☐ No ☐

Our menus are designed with low fat/ low salt

Diet: (please check appropriate diet)

Regular ☐

No salt added ☐

Liberal diabetic (no sugar added) ☐

I approve of a regular diet being served 2x/month for special events Yes ☐ No ☐

If necessary, I approve of transportation time being in excess of one hour. Yes ☐ No ☐

In addition to this patient being approved for their participation in the CBAS program; I authorize the following therapies:

PT ☐ OT ☐ Other ☐ Please indicate:

Summary:

GOLDEN LIFE ADULT DAY HEALTH CARE CENTER

COMMUNITY BASED ADULT SERVICES (CBAS)

9158 Fletcher Parkway, La Mesa, CA 91942-3449
Work Phone (619) 357-7753 - Fax Number (619) 439-6038

MEDICAL INFORMATION / AUTHORIZATION REQUEST/ PHYSICAL EXAMINATION (Page 2 of 2)

Name: _____ **Date of Exam:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ / _____ **Pulse:** _____

EVALUATION OF SYSTEMS:

System Name	Yes	No	Comments/Description
Eyes	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Mouth/Throat	☐	☐	
Head/Face/Neck	☐	☐	
Lungs	☐	☐	
Cardiovascular	☐	☐	
Extremities	☐	☐	
Gastrointestinal	☐	☐	
Endocrine	☐	☐	
Musculoskeletal	☐	☐	
Integumentary	☐	☐	
Renal/Urinary	☐	☐	
Lymphatic	☐	☐	
Nervous System	☐	☐	

Limitations or restrictions for activities: _____

Additional Comments: _____

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

Physician's Phone: _____ **Physician's FAX:** _____

Physician's Address: _____