Adult Day Care of Calvert County
975 Solomons Island Road N
Prince Frederick, Maryland 20678
Phone – 410-535-0133
Fax- 410-535-4094

Physician's Assessment and Initial Order Form

Patient Name: _____**DOB:**_____ **Date**: _____

Base/Line Data: Weight: _____ Height: _____ Blood Pressure: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Past Mental HealthHX:_____

Surgeries/Procedures_____

Systems	**Normal**	**Abnormal**	**History**	**Present Condition**
Cardiovascular System				
Metabolic System				
Respiratory System				
Endocrine System				
Digestive System				
Reproductive System				
Urological System				
Musculoskeletal System				
Nervous System				
Vision				
Hearing				
Other				

Name of Patient: _____

Is the patient oriented to: (please circle all that apply) Person, Place, and/or Time

Is there memory loss or deficit evident with:

Recent Memory: _____ Recall _____ Recognition
Remote Memory: _____ Recall _____ Recognition

Do any of the following apply? (Y- yes; N- no)

Depression _____ Anxiety Disorder _____ Hostility/ Combativeness _____

Is assistance required with: ADL's _____ Mobility _____
Communication _____

Is Patient Continent? Bowels _____ Bladder _____

Does Patient have:

Ventilator _____ Oxygen (frequency) _____ Suctioning _____

Trach Care _____ IV line/ Fluids _____ Tube Feeding _____ Speech Impairment _____

Colostomy/Ilesostomy care ____ Cathetar/Continence care____ Sight Impairment ____

Hearing Impairment _____ Any other Impairment or condition (please indicate)_____

Pressure Sores (indicate location, size, stage, drainage, and signs of infections)

_____

Any History of Seizures? Yes/No

May Attend Adult Day Care _____days per week.

Recommended Diet (the average meal served at Adult Day Care has 1-2 gramsNa,670-850 calories)

(please circle one): Regular, Regular Non Dairy, ADA (no concentrated sweets),

Regular Chopped, Finger Food, Puree, Ensure **,** other_____

Name of Patient: _____

Allergies: (Drug)_____

(Food)_____

(Environmental)_____

Other Treatments/Assessment(B/P monitoring, dressing changes, lab testing ,ect)

Treatment/Test Frequency Administered by:

_____

_____

Medication Orders:

Medication	Dosage/Frequency	Restrictions	Date Started

May take Tylenol 2 tabs p.o. q4h prn for headaches, minor pain, or fever? Yes/No

Name of Patient: _____

Patient Must be Certified free from Tuberculosis **within the last 30 days.**

Skin Test (PPD) Date Planted: _____ Date Read:_____ Results: _____
Or Chest X-ray Date_____
Is Patient Free from Infectious Disease? Yes/ No (circle one)

Please list any current specialty providers this patient is seeing: (please list name, address, phone number, specialty, date last seen, and next appointment date)

I plan to see this patient again on: _____

Date: _____ Signature: _____ M.D.

Print Name of Physician: _____

Mailing Address, :
_____
_____
_____
Phone:_____Fax:_____

Please forward the completed form to Adult Day Care of Calvert County. Thank you for your time and assistance. FAX TO:410-535-4094