OXNARD FAMILY CIRCLE
ADULT DAY HEALTH CARE CENTER
2100 Outlet Center Dr. #380, OXNARD, CA 93036
Phone: (805) 385-4180 FAX: (805) 751-4149

Physician's Authorization/ Participant's Physical and History

(could be returned by fax: 805-751-4149 or email: enrollment@oxnardfamilycircle.com)

Patient Name:	Telephone:
Address:	Female ☐ Male ☐
City/State/Zip	Age: DOB:

*****TB Clearance** (within the last 12 months): *Required prior to Patient attending the ADHC****

Date of test: _____ ☐ Negative ☐ Positive
Method: ☐ PPD Test ☐ Chest X-Ray
I approve an order for the RN to administer a PPD test at the ADHC: ☐ Yes ☐ No
Any indication of communicable disease: ☐ Yes ☐ No

Current Medical Exam (Print Out of the Current Medical Exam could be used instead)

Wt:	Ht:	Temp:	Pulse:	BP:
HEENT	Lungs	**Primary DX (DX & Meds Print-Out could be used instead): DX & Meds Print-Out attached** ☐ Yes ☐ No		**ICD9**
Mouth	Heart			
Thorax	GI			
Breast	Genitourinary	**Secondary DX:**		
Lymphatics	Musculo-skeletal			
Other	Rectal			

ALLERGIES? ☐ No ☐ Yes _____

PROGNOSIS: Excellent/Good/Fair/Guarded/ (circle one)

DIET AND NUTRITION:

☐ Prudent/Diabetic (low fat, low cholesterol, low sodium, high fiber, NCS) ☐ Puree ☐ Chopped
☐ Renal (low potassium, low phosphorous, low sodium, limited protein)
☐ Other _____

SPECIAL ORDERS:

Glucose Testing: (<60, >350 mg/dl) ☐ Yes ☐ No Frequency: ☐ Daily ☐ Weekly ☐ Other: _____
BP Check (<90/60->180/100) ☐ Yes ☐ No Frequency: ☐ Weekly ☐ Other: _____
Oxygen Therapy: 2/L per minute per nasal canula PRN SOB Continuous Other _____
Other: _____

Requested Services: ___RN ___OT ___PT ___Social Work ___Registered Dietitian ___Speech Therapist ___Podiatrist ___Psychological Services

PRN ORDERS while at the center:

Pain
☐ Advil (200mg), 2 tablet, Q 4 hours with food
OR ☐ Tylenol 500 mg, 2 tablets, Q 6 hours
OR ☐ Other: _____

Stomach upset/ Intestinal distress:
☐ Laxative (M.O.M.), 30cc, PRN for constipation
☐ Kaopectate, 2 tablets, PRN for diarrhea
☐ Antacid, 30cc or 1 tablet, Q 4 hours
☐ Pepto Bismol, 30ml, q 30-60 mins, prn diarrhea

MD Signature_____ Date_____

Medication Profile

Med Profile Print-Out could be used instead: Med Profile Print-Out is attached ☐ Yes ☐ No

Participant Name: _____

Date Ordered	Medication & Dosage	Route	Frequency	Diagnosis

I agree that a registered nurse, occupational therapist, physical therapist, social worker and recreational activity coordinator will assess my patient. A registered dietician, speech therapist, podiatrist and psychological consultant may provide care if a need is identified by the multidisciplinary team. A plan of care will be developed, under which care will be provided for the next 6 months. The therapeutic goal is for my patient's level of function to be maintained or improved. I agree that my patient meets the criteria set by CA Code of Regulations Title 22 for attendance in an ADHC program. This requires that there is a medical condition requiring the treatment or rehabilitative services ordered by an MD; a mental or physical impairment which handicaps daily living but not requiring 24 hour institutional care; and a high potential of deterioration and probable institutionalization if ADHC care is not provided.

I APPROVE OF MY PATIENT ATTENDING OXNARD FAMILY CIRCLE ADHC PROGRAM:

Physician Signature:	Date:

OXNARD FAMILY CIRCLE ADHC
2100 Outlet Center Dr. #380, OXNARD, CA 93036

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize Oxnard Family Circle ADHC to obtain any and all information from my medical records and to release the information to authorized members of the interdisciplinary team at Oxnard Family Circle ADHC.

I would like to participate with the ADHC program and would appreciate your assistance in providing Oxnard Family Circle with the necessary information.

Signature of Participant:_____

Signature of Witness:_____

Date:_____

This authorization is effective until otherwise specified by participant. If you have any questions regarding the program or this request, please contact Oxnard Family Circle ADHC at (805) 385-4180 or fax number (805) 751-4149. A photocopy of this release may be considered valid and may be used in place of the original.