2100 Outlet Center Dr. #380, Oxnard CA 93036
Phone: (805) 385-4180 FAX: (805) 751-4149

Physician's Authorization/ Participant's Physical and History

Patient Name:	Telephone:
Address:	Female ☐ Male ☐
City/State/Zip	Age: DOB:
Last Four of SSN:	

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

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

Please Include Diagnosis Print-Out Form w/ Signature from MD

Completed form may be Faxed to (805)751-4149
Or save it encrypted with password "OFC" & e-mail to:
enrollment@oxnardfamilycircle.com

Please Copy & Paste: Current Physician Visit Note, including medications.
Or print and attach.

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

Physician Signature:	Date:

(Could be signed electronically)

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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.