Attention Physicians- Community Care-GEC ADHC- Consult is required

☐Consult Entered on ____/____/_____ Physician Name_____Signature_____

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:
Last Four of SSN:	

*****TB Clearance (within the last 6 months):** *Required prior to Patient attending the ADHC****

Date of test: _____ ☐ Negative ☐ Positive
Method: ☐ PPD Test ☐ Chest X-Ray ☐ **Quantiferon-TB Gold Test**
I approve an order for the nurse 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) ☐Regular ☐Chopped ☐ Finely Chopped ☐ Pureed
☐ Renal (low potassium, low phosphorous, low sodium, limited protein)
☐ Other _____

SPECIAL ORDERS:

Glucose Testing: ☐ Yes ☐ No Frequency: ☐ Daily ☐ Weekly ☐ Other: _____
BP Check : ☐ 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, P.O., Q 4 hours with food PRN pain
OR ☐ Tylenol 500 mg, 2 tablets, P.O., Q 6 hours PRN pain
OR ☐ **Refresh Plus Lubricant Drops- Instill 1-2 drops PRN dry eye(s)**
☐ Other: _____

Stomach upset/ Intestinal distress: ☐ Laxative (M.O.M.), 30cc, P.O., PRN for constipation
☐ Kaopectate, 30ml, P.O., PRN for diarrhea not to exceed 8 doses in 24 hrs.
☐ Antacid, 20ml or 2 tablets P.O., Q 4 hours PRN Heartburn/Upset stomach
☐ Pepto Bismol,30ml, P.O., Q 60mins, PRN diarrea not to exceed 8 doses in 24hrs

Is your patient able to self-administer his/her medications? ☐YES
☐NO

Is your patient stable to ride a bus/van for over an hour? ☐YES ☐NO

Physician Phone Number:	**Physician email address:**
Physician Name: **(please print)**	**Physician 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 Name: **(please print)**	**Physician Signature:** **Date:**

OXNARD FAMILY CIRCLE
ADULT DAY HEALTH CARE CENTER

HIPAA Privacy Authorization Form

Effective Date: _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Pans 160 and 164)

1. Authorization. I, _____, authorize _____ to use and disclose to protected health
(name of healthcare provider)
information described below to a business entity known as Oxnard Family Circle ADHC.

2. Effective Period. This authorization for release of information covers all past, present, and future periods of health care.

3. Extent of Authorization. I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, treatment of alcohol or drug abuse).

4. Use. This medical information may be used by the entity I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. Termination. This authorization shall be in force and effect until the date of _____, at which time this authorization form expires.

6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Participant's Name _____Signature _____
(or **Personal Representative**)

Date _____