

Renewal date of assessment form: _____

Renewal date of TB: _____

(for office use only)

Franciscan Adult Day Center

2715 Pamoia Road, Suite 103 Honolulu, Hawaii 96822 Phone: (808) 988-5678 fax: 988-1179

Health and Physical Form

(to be completed by participant's physician, examining nurse or physician's assistant)

I. Personal information

Name _____ Address _____

Birthdate _____ Gender _____ Marital Status _____ Ethnicity _____

Physician _____ Address _____

Phone _____ Exchange _____

II. Physical / Mental status

Diagnosis: Primary: _____ Secondary: _____

Major medical problems: _____

Psychiatric history: _____

Allergies _____ Reaction to allergen _____

Height _____ Weight _____ Pulse rate _____ Resp _____ BP _____

Vision _____ Hearing _____

Neck / Head _____ Lungs _____

Heart _____ Back / Skeletal _____

Abdomen _____ Extremities _____

Ambulation _____

TB Test or Chest X-Ray: Given on: _____ Location: _____

Result: _____

State of Hawaii Regulations require annual TB clearance for day care enrollment.

Testing at DOH clinic may be substituted for testing by primary care physician.

Date, number of days, and reason of last hospitalization (if any): _____

Current physician orders:

Diet: Regular _____ Special _____

Medications: (name, dosage, time to be given) *Attach extra sheet if needed.*

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

May aspirin/Tylenol be given? Yes _____ No _____
Should vital signs be taken? _____ How often? _____

III. Functional Level

	Independent	Supervised	Assist (How many person?)
Eating	_____	_____	_____
Dress/groom	_____	_____	_____
Bathing	_____	_____	_____
Toileting	_____	_____	_____
Transferring	_____	_____	_____
Walking/mobility	_____	_____	_____

History of falls? _____ When _____
Incontinence: Bowel _____ Urine _____ Foley cath _____ Condom cath _____
Physical aids: Dentures _____ Eyeglasses _____ Hearing aid _____
Colostomy _____ Prosthesis _____ Walker _____
Cane _____ Specify _____

Participant may take part in sitting/standing exercises for older adults?
Yes _____ No _____ Comments _____

IV. Social

Primary caregiver _____ Relationship _____
Pertinent family medical history _____
Support person/network _____

V. Environmental

Resides: Alone _____ Family _____ Other _____
Resides in: House _____ Apartment _____
Any stairs at home? _____ If yes, how many? _____
Any other physical barriers? _____

VI. Other pertinent information:

I certify that this individual's medical condition and related needs are essentially as indicated above and participation in an adult care program is appropriate.

Health Care Provider signature/title

Date