JABA's Adult Care Center
674 Hillsdale Dr., Suite 9, Charlottesville, VA 22901
Phone: (434) 817-5269 Fax: (434) 817-5230

Participant History and Physical Form

Report of Participant's Physical Examination – initial to be completed *not more than* 30 days prior to the date of acceptance for admission, with updates completed annually. The participant cannot be admitted nor retained in daycare without these completed physicals. This report will be kept as part of the client's permanent record. **Please fill in every section.**

NAME: _____Date of Birth: _____

ADDRESS: _____

_____ TEL: # _____

1. **Date/ Place of Examination:** _____

BP _____/ _____ Temp _____ Pulse _____ Respirations _____
Height_____ft._____in. Weight_____lbs.

Diagnoses:
Primary: _____

Contributory: _____

Secondary: _____

Present Level of Cognitive Functioning: _____
General Appearance:

EENT: _____ Neck: _____
Chest: _____ Heart: _____
Abdomen: _____ Spine: _____
Extremities: _____ Skin: _____
Pelvic: _____ Rectal: _____

History of Illnesses:

Arthritis_____	Alzheimer's_____	CVA_____
Cancer_____	Other Dementia_____	Heart Disease_____
Diabetes_____	Dizziness_____	Hypertension_____
Kidney Disease_____	Neurological_____	Parkinson's_____
Tuberculosis_____	Seizures_____	Thyroid_____
Allergies_____	Depression_____	Other_____

Please list any previous hospitalizations for injury, surgery, illness, etc.:_____
_____
_____
_____
Please list all known medicinal and food allergies: _____
_____
_____
Any other allergies? (Ex. latex, bee stings)_____

Is this person capable of administering his/her own medication without assistance? _____

2. **DATE of screening for TUBERCULOSIS** according to accepted methods of the Virginia Department of Health: **Type of Test:** _____
TEST DATE: _____ **DATE READ:** _____
Test Results: _____

Standards permit the initial screening for tuberculosis to be the tuberculin skin test. Each person, whose physician certifies the absence of tuberculosis in a communicable form, even though the test is significant (positive), must obtain a chest X-Ray on an annual basis for the following two years.

This person is _____, is not _____, free of tuberculosis in a communicable form.

If it is medically inappropriate for this person to have a tuberculin test, please check. _____

****THE PATIENT MUST BE TESTED FOR TUBERCULOSIS NO MORE THAN 30 DAYS PRIOR TO ADMISSION TO THE FACILITY.**

Does this person have a condition that requires isolation? If yes, please explain: _____
_____
Date of positive test: _____ Next date for organism testing: _____

3. **Recommendations for care:**
   A. Diet (check one): Regular_____ No Salt Added _____ No Concentrated Sweets_____
   Patient requires foods: Chopped _____ Pureed _____ Needs Ensure Daily _____
   Foods client should **not** have (such as nuts or milk products) _____
   _____
   B. Specific treatments and/or therapies: _____
   _____
   C. Please indicate the condition of the client's teeth and oral health._____
   _____

D. **Medications & Dosages: THIS SECTION IS A MUST, PLEASE WRITE CLEARLY**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

E. **ATTENTION:** Please list medications you would like the client to receive PRN, for pain, fever, indigestion, diarrhea or skin abrasions. The family must provide the medication with the client's name on the original container or bottle.

_____
_____

F. Please indicate the **necessary routine medications** which the client must receive while attending JABA ACC. **List the medication, route & dosage.**

_____
_____
_____
_____

F. **Mental Condition:**

Has patient been hospitalized for mental illness? _____
If so, what diagnosis: _____
When and how many times? _____
Results: _____
Any history of aggressive behavior or dangerously agitated states: _____
_____
Senility: Slight_____ Moderate_____ Advanced_____
History of drug addiction or excessive alcohol intake: _____

4. Does this person need any type of restraint to provide physical support because of a weakened condition? _____

5. In your opinion, is your patient's physical condition such that in an emergency he/she can exit from the building without assistance from another person? _____

6. In your opinion, does this person have the sensory and mental ability to perceive an emergency and exit from the building without the assistance of another person? _____

7. Does the individual have any of the following conditions or care needs?

   Dermal ulcers or wounds which are open? _____ If yes, describe: _____
   _____
   Any infectious disease in a communicable state which requires isolation or special precautions to prevent transmission? _____ If yes, describe: _____
   _____
   Does this person require skilled nursing care for ventilator dependency, intravenous therapy, Nasogastric, Gastric Tubes or any type of skilled nursing care not listed? _____ Please describe: _____

8. Please list any other restrictions on physical activities beyond those noted in the History and Physical? _____
   _____

9. Does the client have Advanced Directives? _____
   Does the client have a "DNR" Order? _____ **Please note, we must have a copy for the JABA Adult Care Center.**

10. Further comments: _____
    _____
    _____

_____ _____
Physician's Signature Date

Please print or type the physician's name, address, telephone and fax numbers:

Address: _____

_____

_____

_____

Telephone: _____ Fax: _____

JABA's Adult Care Center is licensed by the Department of Social Services, Commonwealth of Virginia. Participants in need of skilled nursing care qualify for Medicaid, provided they meet financial criteria.