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 ______Mechanical 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.