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Mercy Neighborhood Ministries of Philadelphia, Inc.

Medical Evaluation for Adult Day Services

Participant Name: _____ Date of Birth: _____ Date of Exam: _____

Address: _____
Street City State Zip Code

Brief HPI/Diagnosis: _____
_____
_____

HEALTH HISTORY

Past History

Stroke	☐ yes	☐ no	Dates _____
Diabetes	☐ yes	☐ no	Dates _____
TB	☐ yes	☐ no	Dates _____
Heart Disease	☐ yes	☐ no	Dates _____
Mental Illness	☐ yes	☐ no	Dates _____
Other	☐ yes	☐ no	Dates _____
_____			Dates _____
_____			Dates _____

Sensory Aids: Glasses ☐ yes ☐ no
Hearing Aid ☐ yes ☐ no

Allergies or Drug Sensitivities ☐ yes ☐ no
If yes, list: _____
_____
_____

Hospitalization in past 3 months: ☐ yes ☐ no
Reason: _____
_____
_____

Please explain any "yes" to the above: _____

COMMUNICABLE DISEASE

1. **Is patient free of communicable disease/infection?** ☐ yes ☐ no
   If communicable disease is present, what precautions must be taken to prevent spread in group setting?
   _____
   _____
2. TST (Tuberculin skin test – PPD) - Mandatory
   Date given: _____ Date Read: _____
   Results: _____ If positive, provide copy of recent chest X-Ray.
3. Vaccinations:
   Pneumovax: ☐ no ☐ yes Date: _____ Influenza: ☐ no ☐ yes Date: _____

Flu Vaccine is REQUIRED for attending Adult Day Program

Functional Status: (Circle one level for each item listed below)

	Level 1	Level 2	Level 3	Level 4
Eating	Self	With assist	Total care	
Bathing	Self	With assist	Total care	
Dressing	Self	With assist	Total care	
Urination	Continent	Occas. Incontinent	Incontinent	Catheter
Defecation	Continent	Occas. Incontinent	Incontinent	Colostomy
Mentation	Clear	Occas. Confused	Confused	
Noisy	Never	Occasionally	Most of the time	
Agitation	Never	Occasionally	Most of the time	
Depression	Never	Occasionally	Most of the time	
Combative	Never	Occasionally	Most of the time	
Withdrawn	Never	Occasionally	Most of the time	
Wanders	Never	Occasionally	Most of the time	
Suicidal	Never	Occasionally	Most of the time	
Mobility	Ambulatory	Cane/Walker	Wheelchair	Chair bound
Sight	Not impaired	Impaired	Blind	
Hearing	Not impaired	Impaired	Deaf	
Speech	Not impaired	Impaired	Aphasia	

Activity Permitted: ☐ Full ☐ Limitations/Specify: _____

Participant is capable of administering his/her own medications:
Self _____ Under supervision _____ No _____

Comment: _____

Physical Exam:

Height _____ Weight _____ BP _____ Pulse _____ RR _____ Temp _____

Vision: _____w/glasses _____w/o glasses _____near vision

Eyes	☐ WNL	☐ Other _____
Ears	☐ WNL	☐ Other _____
Nose	☐ WNL	☐ Other _____
Throat	☐ WNL	☐ Other _____
Mouth	☐ WNL	☐ Other _____
Neck	☐ WNL	☐ Other _____
Breasts	☐ WNL	☐ Other _____
Heart	☐ WNL	☐ Other _____
Lungs	☐ WNL	☐ Other _____
Abdomen	☐ WNL	☐ Other _____
Back & Spine	☐ WNL	☐ Other _____
Neurologic	☐ WNL	☐ Other _____
Extremities	☐ WNL	☐ Other _____
Skin	☐ WNL	☐ Other _____

If NOT WNL please explain:_____

Use of Medical Treatments or Therapies ☐ Yes ☐ No Explain: _____

_____

_____

Physician Orders:

Diet: ☐ No Restrictions ☐ No Added Salt ☐ No concentrated sweets

☐ Other--Specify _____

Medications:

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Physician Name: _____

Address _____

Street City State Zip Code

Telephone Number: _____ Fax number: _____

_____ _____

Signature Date