

Mercy Neighborhood Ministries of Philadelphia, Inc.Medical Evaluation for Adult Day Services

1939 W. Venango Street Philadelphia, PA 19140 tel 215-227-4393 fax 215-227-4394 www.mercyneighbors.org

Date given:	Participant Name:			Date of Birth:	Date	Date of Exam:	
Bright HPI/Diagnosis:	Address:	Street		City	State	Zin Codo	
Sensory Aids: Glasses yes no no Nates no Hearing Aid yes no no Nates no Dates no				·		sip code	
Past History	Brief HPI/Diagn	osis:					
Past History							
Stroke					Hearing Aid	□ yes □ no	
Diabetes	Stroke	Пиес	□ no Dates	-			
Carlo							
Heart Disease yes no Dates D							
Mental Illness				Hospit	alization in past 3 months	s: \square ves \square no	
Dates		•					
Dates Date			□ no Dates		·		
Dates Dates Dates Dates Dates Dates Dates Dates Date		_	Dates				
Please explain any "yes" to the above:			Dates				
Is patient free of communicable disease/infection? yes	Please explain ar	ny "yes"	to the above:				
If communicable disease is present, what precautions must be taken to prevent spread in group setting? TST (Tuberculin skin test – PPD) - Mandatory Date given:	COMMUNICA	BLE DI	SEASE				
Date given:						setting?	
Date given:	2. TST (Tubero	culin ski	n test – PPD) - Mano	latory			
Results:				-			
Pneumovax:	Results:				recent chest X-Ray		
Pneumovax:				in positive, provide copy of	recent enest A Ray.		
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 Bating Self With assist Total care Bathing Self With assist Total care Dressing Self With assist Total care Drination Continent Occas. Incontinent Incontinent Catheter Defecation Continent Occas. Incontinent Incontinent Colostomy Mentation Clear Occas. Confused Confused Noisy Never Occasionally Most of the time Depression Never Occasionally Most of the time Depression Never Occasionally Most of the time Withdrawn Never Occasionally Most of the time Withdrawn Never Occasionally Most of the time Wanders Never Occasionally Most of the time Wanders Never Occasionally Most of the time Most of the time Wanders Never Occasionally Most of the time Worders Never Occasionally Most of the time Mobility Ambulatory Cane/Walker Wheelchair Chair bound Bight Not impaired Impaired Blind Hearing Not impaired Impaired Deaf Participant is capable of administering his/her own medications: Self Under supervision No Under supervision No			□ ves Date:	Influenza	· □ no □ ves Date:		
Circle one level for each item listed below	i neumo vax.	. 🗀 110	□ yes Bute	Flu Vaccine is RE			
Level 1 Level 2 Level 3 Level 4	Functional Stat	us:	(Circle one level for			, 8	
Self With assist Total care			\		Level 3	Level 4	
Self With assist Total care	Eating						
Dressing Self With assist Total care Drination 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 Depression Never Occasionally Most of the time Depression 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 Deaf Activity Permitted:			Self				
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Speech Not impaired Impaired Aphasia Activity Permitted: Participant is capable of administering his/her own medications: Self Under supervision No	•	\longrightarrow		•			
Activity Permitted:				1		+	
Participant is capable of administering his/her own medications: Self Under supervision No		1.			Apnasia		
Self Under supervision No							
ATTITUMUI	Self Comment:		Under supervision	No			

Physical Exam:					
Height	Weight _	BP	_ Pulse	RR	Temp
Vision:v	v/glasses	w/o glasses	near vision	near vision	
Eyes	□ WNL	□ Other			
Ears	□ WNL	☐ Other			
Nose	□ WNL	☐ Other			
Throat	□ WNL	☐ Other			
Mouth	□ WNL	☐ Other			
leck		☐ Other			
Breasts		☐ Other			
Ieart	□ WNL	☐ Other			
Lungs	□ WNL	☐ Other			
Abdomen	□ WNL	☐ Other			
Back & Spine	□ WNL	Other			
		Other			
Neurologic	□ WNL	Other			
Extremities	□ WNL	Other			
Skin	□ WNL	☐ Other			
If <u>NOT</u> WNL plea Use of Medical Trea		s □ Yes	□ No Ex		
osc of Miculcal Tica	unicitis of Therapie	S 🗀 1 CS	LINO EX	piaiii	
□ Medications:	OtherSpecify				
Medication	Dosage	Frequency	Medication	Dosage	Frequency
				+	
				+	
				+ +	
hysician Name:					
-					
Address					
Str	eet	City	State	Zip	Code
elephone Number:			Fax number: _		
			_		
Signature			Date		