3953 Pender Drive, Suite 100
Fairfax, VA  22030
Voice (703) 204-4664
Fax (703) 204-0509
www.InsightMCC.org

# INSIGHT MEMORY CARE CENTER

## REPORT OF PARTICIPANT PHYSICAL EXAMINATION--ADULT CARE PROGRAM

Examination is to be completed by or under the direction of a licensed physician either within 30 days prior to acceptance for admission or within 30 days prior to admission.

Name of Applicant:________________________________
Applicant Address:________________________________
________________________________________________
Applicant Phone Number: __________________________
Applicant Date of Birth:____________________________

Print Physician's Name:______________________________
Physician's Address: ________________________________
________________________________________________
Physician's Phone Number:___________________________
Physician's Fax Number:_____________________________

**Medical History and Current Status**

Present Diagnoses and/or significant medical problems:

________________________________________________________________________

Other Disabilities: (Please Specify)

________________________________________________________________________

| | | | | | |
|---|---|---|---|---|---|
| **Allergies & Sensitivities:**<br>(inc. medications, food, animal): | | | | | |
| **Reactions:** | | | | | |

**Code Status (please check one)**:

☐ Full Code

☐ DNR  ***(If DNR, please provide signed DNR form.)***

**Relevant History**

Physical History:_______________________________________________________________
Mental History: _____________ __________________________________________________
Fracture History:_______________________________________________________________
Fall History:___________________________________________________________________
Recent Surgery:_________________________________________________________________
Recent Hospitalization:__________________________________________________________
Immunization History: ___________________________________________________________
History of Drug Addiction or Excess Alcohol Intake:_______________________________________

**Physical Examination**: Blood Pressure: _______  Pulse:______  Weight:_______  Height:_______  Temp: _________

Please see attached tuberculosis screening evaluation **(must be dated within 30 days prior to acceptance or admission).**

**Signature of Physician**:______________________  **Date of Physical**:____________

## Recommendations for Care:

**MEDICATIONS:**

Please complete IMCC's Medication List (enclosed on page 3) for all prescribed and over the counter medications, vitamins, and supplements. ****Insight CANNOT accept printed out medication lists as attachments. All medications must be documented on pg. 3.****

**LIMITATIONS:**

1. Is this person capable of administering his/her own medications without assistance?

   ☐ No, due to dementia

   ☐ Yes

2. Is this person physically and mentally capable of self-preservation by being able to respond in an emergency to make an exit from the building or to a safe refuge in an emergency without assistance of another person, even if he/she may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command?

   ☐ No, due to dementia

   ☐ Yes

3. Does this person have any restrictions/limitations on physical activities or program participation?

   ☐ No

   ☐ Yes (**indicate type** of restrictions/limitations): ________________________________________

**DIET:**

☐ Regular ☐ Controlled Carbohydrates ☐ Mechanical Soft ☐ Pureed

☐ Other: __________________________________________

Special diet or any food intolerances: __________________________________________________

***Please list any nutritional supplements (**Ensure, Glucerna, etc**.) on attached Medication List.***

**THERAPY** :

List therapy (-ies), treatments or procedures the patient is undergoing or should receive and by whom:

____________________________________________________________________________________________

Other: ____________________________________________________________________________________

**Signature of Physician**:_________________________ **Date of Physical**:___________________

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# Medication List

**All prescription medication, nutritional or other supplements, OTC medications, and vitamins MUST be completed ON THIS FORM (in the chart below). **Insight CANNOT accept "see attached" lists.****

| Name of Medication | Dosage | Route | Frequency of Administration | Meds Given at Home or Center (Circle) | Diagnosis |
|---|---|---|---|---|---|
| *Example: Tylenol* | *325mg* | *PO* | *2 Tabs Q6H PRN* | *Home* [✓ *Center*] | *Headache* |
| *Example: Ibuprofen* | *200mg* | *PO* | *2 Tabs BID – 1pm Dose Given at Center* | *Home* [✓ *Center*] | *Shoulder Pain* |
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***Discontinue ALL PRIOR ORDERS as this is a current and updated set of orders effective the date indicated below.***

**Signature of Physician:**______________________________ **Date of Physical:**______________________

**********Since a Physician's Order is required for medication or treatment at the Center, please sign the above.**********

Participant Name: ____________________________ DOB: __________________

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# Report of Tuberculosis Screening

**Name ___________________________** **Date of Birth _______________**

**To Whom It May Concern:**

**The above named individual has been evaluated by ____________________________________________**

**(Name of health dept/facility)**

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis risk factors for developing active TB or known recent contact exposure. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ A tuberculin skin test (PPD) was administered on _______________ and results, read on ______________, were as follows: ______ mm _____ Negative _____ Positive.
*Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual either is currently receiving or has completed adequate modification for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual had a chest x-ray on ____________ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual had an *abnormal* chest x-ray on ____________. **Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.**

**Signature** :__________________________ **Date** _______________________
(MD or Health Department Official)

Address: ___________________________________ Phone ______________________
___________________________________
____________________________________