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: (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 *Example: Ibuprofen*	*325mg* *200mg*	*PO* *PO*	*2 Tabs Q6H PRN* *2 Tabs BID – 1pm Dose Given at Center*	*Home Center* *Home Center*	*Headache* *Shoulder Pain*
				Home Center	
				Home Center	
				Home Center	
				Home Center	
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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: ___________________

Virginia Tuberculosis (TB) Risk Assessment

For use in individuals 6 years and older

First screen for TB Symptoms: ☐ None (If no TB symptoms present → Continue with this tool)

☐Cough ☐Hemoptysis ☐Fever ☐Weight Loss ☐Poor Appetite ☐Night Sweats ☐Fatigue

If TB symptoms present → Evaluate for active TB disease

Use this tool to identify asymptomatic **individuals 6 years and older** for latent TB infection (LTBI) testing

- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment
- A negative Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) does not rule out active TB disease

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the risks below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

☐ Birth, travel, or residence in a country with an elevated TB rate ≥ 3 months

- Includes countries other than the United States (US), Canada, Australia, New Zealand, or Western and North European countries
- IGRA is preferred over TST for non-US-born persons ≥ 2 years old
- Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism < 3 months may be considered for further screening based on the risk estimated during the evaluation.

☐ Medical conditions increasing risk for progression to TB disease

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunoileal bypass, solid organ transplant, head and neck cancer

☐ Immunosuppression, current or planned

HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ Close contact to someone with infectious TB disease at any time

☐ None; no TB testing indicated at this time

Patient Name ______________________ Provider Name ______________________

Date of Birth ______________________ Assessment Date ______________________