Instructions for IMCC Physical & TB Paperwork

In order to facilitate a smooth transition to Insight Memory Care Center, we ask that you please work with your physician to ensure all areas of the physical and TB form are filled out accurately and completely.

The following instructions note common errors found on the physical and TB forms for admission to IMCC. *Please note that physicals that are not filled out correctly WILL cause a delay in admission to the center.*

We thank you for your assistance in this matter!
IMCC Staff

Instructions: Each numbered instruction corresponds to an area noted on the physical or TB form. Please refer to the physical and TB forms.

Page 1

1. *Medical History and Current Status.* MUST include: a DIAGNOSIS OF DEMENTIA, Alzheimer's, mild cognitive impairment, or other memory loss/cognitive decline.

2. *Allergies*. All allergies must be noted. If no allergies are known, have the doctor simply write "none."

3. *Code Status.* Code status MUST be checked either "Full Code" or "DNR," which stands for Do Not Resuscitate. **IF** your loved one wishes to have a DNR code status, there is a State of Virginia one-page form that must be filled out and signed by the POA and the physician. This is separate from any prior advanced medical directives or living will your loved one may have. There is no fee for a DNR form.

4. *Relevant History*. Please write all relevant history on the lines provided. If there is none, please have the physician write "none" on the line.

5. Physician must sign at the bottom of each page.

6. Physician must date the bottom of each page. For new admissions, the date of the physical **MUST be within 30 days prior to their first official day at the center** (NOT their intake assessment).

Page 2

7. Medications MUST all be listed **on p. 3 on IMCC's form**, with **all information in each column complete, whether the medications are taken at home or at the center**. Insight **CANNOT accept "see attached" medication lists.** The medication list will be given to the emergency squad in the event of a medical emergency, so complete, accurate information is crucial!

8. *Limitations #1.* MUST be checked “NO” due to dementia, according to state adult day health center regulations.

9. *Limitations #2.* MUST be checked “NO” due to dementia, according to state adult day health center regulations.

10. *Limitations #3.* If “YES” is checked for restrictions/limitations on physical activity, the doctor MUST indicate what those restrictions are.

11. *Diet*. Please check one of the provided diets, and indicate any special dietary restrictions or food intolerances on the line provided.

12. Physician must sign at the bottom of each page.

13. Physician must date the bottom of each page.

Page 3

14. *Medication List.* All prescription medications, over the counter medications, and nutritional or other supplements MUST all be listed **on p. 3 on IMCC’s form**, with **all information in each column complete, whether the medications are taken at home or at the center**. Insight **CANNOT accept “see attached” medication lists.** The medication list will be given to the emergency squad in the event of a medical emergency, so complete, accurate information is crucial!

> *For medications to be given at the center, please review Insight’s Medication Rules to help ensure compliance with our state regulations. Insight will need the prescription, the medication in the original bottle (unexpired) with a matching prescription label affixed. Participants will not be able to attend the center if there is an order to administer medication that Insight’s nurse has not been provided by the family.

15. Physician must sign at the bottom of each page.

16. Physician must date the bottom of each page.

Page 4

17. *Report of Tuberculosis Screening*. The doctor must check one of the circled lines for admittance to the center. Please note that your physician may check the first line, stating that a PDD test is not indicated at this time due to the absence of symptoms.

18. Physician must sign at the bottom of each page.

19. Date **MUST be within 30 days of your loved one’s first day at the center**, according to state adult day health center regulations.

insight MEMORY CARE CENTER

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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: ______________________	Print Physician's Name: ____________________
Applicant Address: ______________________	Physician's Address: ______________________
____	____
Applicant Phone Number: __________________	Physician's Phone Number: _________________
Applicant Date of Birth: __________________	Physician's Fax Number: __________________

Medical History and Current Status

1.

Present Diagnoses and/or significant medical problems:

____

Other Disabilities: (Please Specify)

____

2.

Allergies (inc. medications, food, animal): ____

Sensitivities to Medications: ____

Code Status (please check one):

3.

☐ Full Code

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

Relevant History

4.

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: ______ Other: ____________

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

Signature of Physician:______________________________ 5. **Date of Physical:**_______________ 6.

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.****

7.

LIMITATIONS:

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

8.

☐ 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?

9.

☐ No, due to dementia

☐ Yes

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

10.

☐ No

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

DIET:

11.

☐ Regular ☐ Controlled Carbohydrates ☐ Low Fat ☐ Mechanical Soft

☐ Pureed ☐ No Added Salt ☐ Restricted

☐ Other: ______________________________

Special diet or any food intolerances: ____

Fluid limitation (Please Specify) ____

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: ____

12.

13.

*10.

Signature of Physician:___________________________________ **Date:**________________

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14.

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:________________________________ **15.** ____

Date:________________ **16.**

**********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.

17.

____ 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.**

18. **19.**

Signature ____________________________________ **Date** ________
(MD or Health Department Official)

Address: ____________________________________ Phone _____________________
____
____

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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 (inc. medications, food, animal): ______________________________________

Sensitivities to Medications: ______________________________________

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: ______ Other: __________

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 ☐ Low Fat ☐ Mechanical Soft

☐ Pureed ☐ No Added Salt ☐ Restricted

☐ Other: ______________________________

Special diet or any food intolerances: ____

Fluid limitation (Please Specify) ____

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:**________________

Participant Name: ____________________________ DOB: _______________

Medication List

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				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.

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**********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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Signature ___________________________________ **Date** _________
(MD or Health Department Official)

Address: ___________________________________ Phone ____________________
____
____