MIKKON ADULT DAY HEALTH CARE CENTER

明康成人日間保健中心

2211 EAST GARVEY AVE,NORTH

WEST COVINA, CA 91791

TEL:626-967-0812 FAX:626-967-9286

歡迎來到明康成人保健中心:

請家庭醫生詳細填妥申請表，並有胸部 X-光報告（有效期一年內）。兩項均完成後，請致電明康中心，安排入會手續。

下次來訪時請準備以下資料：

Please bring the items below when you come and visit Mikkon Adhc:

1. California ID 加州身份證/駕照
2. Social Security Card 社安卡
3. Medi-Cal Card 白卡（州政府醫療卡）
4. Medicare Card 紅藍卡（如有）
5. Managed Care Insurance Card 保險公司醫療卡
6. PCP's H&P Form and TB clearance or Chest X-Ray report (申請表，X-光胸片或皮下測試結果)
7. Emergency contact person name and contact information 緊急聯絡人姓名電話

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Tel: 626-967-0812 Fax: 626-967-9286

MIKKON ADHC

PHYSICIAN'S HEALTH ASSESSMENT

Name: LAST FIRST			DOB:	MR#:
Age:	Weight:	Height:	☐ Male	☐ Female

BP range:	PR range:	BS range:	Allergies:

General:	Skin:
H.E.E.N.T.:	Heart:
Chest /Lungs:	Abdomen:
Neurological:	Genitourinary:

DIAGNOSIS & MEDICAL HISTORY: (please mark all appropriate items)			
	Alzheimer		Hyperthyroidism(Grave's Disease)
	Angina Pectoris		Hypothyroidism(Myxedema)
	Arrhythmia		Hyperlipidemia
	Anxiety		Hearing Loss: R. L.
	Arthritis		Incontinence
	Asthma		Insomnia
	ASHD		Myocardial Infarction
	BPH		Meniere's Disease
	Blind: R. L.		Osteoarthritis
	CVA		Osteoporosis
	CAD		Obesity
	CHF		Peptic Ulcer Disease/Gastritis
	COPD		Parkinson's Disease
	Cataract: R. L.		S/P Pacemaker
	Cardiomegaly		Renal Insufficiency
	DJD		Rheumatoid Arthritis
	DM/NIDDM		S/P CVA with L/R Hemiplegia/Hemiparesis
	Dementia		S/P CABG
	Depression		S/P Fx. (location):
	Deafness: R. L.		S/P Hip/knee Replacement: R. L.
	Delusion Disorder		Hx of TIA
	Dizziness		Vertigo
	ESRD		Vision Impairment: R. L.
	Glaucoma: R. L.		Other:
	Gout		Other:
	HTN		Other:

Medications	Dosage & Frequency	Indication	Medications	Dosage & Frequency	Indication

Please see attached meds list

Participant name:_____ #_____

TB CLEARANCE:	PPD Test Date Administered:_____ Date Read: _____ ❑ Positive ❑ Negative	Chest X-Ray Date:_____ ❑ No Active TB

All participants of the CBAS are monitored by a Registered Nurse who will notify you of any significant changes.

Diabetes: ❑ Yes Check BS 1x/wk & PRN NOTIFY M.D. if BS: >300, <60 mg/dl	HTN: ❑ Yes NOTIFY M.D. if BP: >180/100, <80/50 mmHg
Please change parameter as needed. Range:_____	Please change parameter as needed. Range: _____

Diet Order:

❑ Regular/Heart Healthy (No added salt/No added fat) ❑ Low salt/cholesterol/fat diet
❑ No Concentrated Sweet (NCS)/ADA Diet ❑ Renal Diet

Diet Texture: Please specify as needed: _____

May we have a standing order for PRN medication available at center:

If no preference indicated, then all below will apply	Yes	No
Antacid/Mylanta 2 – 4 tabs prn for gastric discomfort		
NTG 0.4mg SL for Chest Pain: 1 dose every 5 mins x 3 doses If not relieved call 911		
Oxygen 2-4 liter PRN for acute SOB		
Tylenol ES 500 mg 1 -2 tabs Q4hrs prn for pain or fever		

Is this patient capable of self-administration of medications? ❑ Yes ❑ No

I agree my patient to attend CBAS center ❑ Yes ❑ No

Special Disciplines Needed as below:

- ❑ Nursing
- ❑ Physical Therapy/Occupational Therapy
- ❑ Social Service
- ❑ Other:

Physician's Printed Name License # Physician's Signature

Address Phone/Fax

City, State, Zip Date