BON HOMIE LTD.
ADULT DAILY LIVING CENTER

Annual Medical Evaluation Form

*This form **MUST** be filled out and signed by the examining physician, NP, or PA, a stamped signature or practice stamp will not be accepted as substitution for the practitioner's signature.*

Name: _____ Date:_____

Address:_____

Age: _____ DOB:_____ Sex: Male / Female

*In the event of an emergency this client should be transported to _____ hospital. (This information will be shared with the ambulance crew, however final destination is at their discretion based upon patient condition at the time of transport.)

*Does this client have a Living Will or Advanced Directive: ___Yes, (please attach a copy) ___ No

Health History

Neurologic: _____

Cardiovascular: _____

Respiratory: _____

GI/GU: _____

Endocrine: _____

Other: _____

_____

Surgical History:_____

_____

Allergies to Foods: _____

Allergies to Medications:_____

470 North Lewis Road, Limerick PA 19468 • 610-792-8800 • Fax 610-792-8820 • www.bonhomieadc.com

Annual Medication Reconciliation:

(Please list ALL medications this client takes both prescribed and over-the-counter)

_____ This client is not currently on any medications.

Medication	Dosage	When is it taken?	Why is it taken?

- Please attach a list for additional medications.

Assessment

T: _____ HR:_____ BP: _____ Resp:_____ Hgt: _____ Wgt: _____

Physical Assessment	**Check if normal**	**Describe Abnormalities**
Head/Neck		
Eyes-cataracts, glasses, glaucoma		Is further evaluation recommended by specialist? [ ] Yes [ ] No
Ears- Hearing aids, deaf		Is further evaluation recommended by specialist? [ ] Yes [ ] No
Nose/Throat		
Mouth/Teeth/Gums		
Speech		
Cardiovascular/edema		
Lungs- Oxygen Use		
Abdomen- G-Tube		
Extremities- Ambulation		
Skin		
Neuro		

Assessment continued

**Any other medical information pertinent to diagnosis and treatment of client in the event of an emergency. Please include and physical limitations,& copies of pacemaker and medical device cards when applicable:_____

_____

_____

Immunization Dates

Tetanus/DPT: _____ (Mandatory every ten years for clients under the age of 65.)

T.B. Mantoux: (Mandatory every 2 years)

Tuberculin Test Date Applied	Arm Used For Testing	Manufacturer / Expiration	Signature/Credentials
Date Read	Induration (+/-)	Results (mm)	Signature/**Credentials**

*If Positive or recent exposure please list Chest X-ray results, treatments, and dates:_____

_____

The following are not mandatory; however, please include dates if applicable:

Hepatitis B: _____/_____/_____ Hepatitis A: _____/_____

Influenza: _____ Pneumonia:_____

This client is clear and free of all communicable diseases. ____ Yes ____ No

If No please indicate disease and any specific precautions that must be taken in order to prevent the spread of disease to other staff and clients: _____

_____

Annual Order Update

*Special Nutritional Orders: Please complete attached dietary needs sheet.

**Use of Medical treatments or therapies recommended:_____

_____

_____

***Any lab tests indicated or ordered at this visit: _____

_____

Annual PRN Medication Orders **Clients Name: _____**

In addition to regularly schedules daily medications listed on page one of the medical evaluation this individual may be given the following medications as prescribed: (Note: No intravenous, intra muscular, or subcutaneous injections can be given while at the center due to lack of continuous nursing coverage.)

For Which Symptoms	Medication Name	Dosage & Route	Frequency
Pain and Fever			
Cold and Cough			
Hypoglycemia **			
Seizure Activity			
Other:			
Other:			
Other:			

* Tylenol and Advil are kept at center for general use.
**15 Gram Carbohydrate Tablets kept at the center for known diabetics.

Over-the-Counter medications that are contra-indicated for this patient include:

_____

Permission is granted by the below signed practitioner to administer these medications on an as needed basis only as specified above. It remains the responsibility of the client's family or caregiver to supply Bon Homie Ltd. with these medications as needed based on the client's condition.

Additional prescriptions for over-the-counter medications being utilized for sporadic care may be faxed to Bon Homie Ltd. either on this form or on an original prescriptive pad including the above information to (610)792-8820.

_____ _____
Practitioner's Name Printed **Sign**

_____ _____
DEA # **Date**

_____
Office Address

_____ _____
Office Phone Number **Fax**

Prescribed Diet, Consistencies, & Textures

Client Name: _____ Program: Bon Homie Ltd.

Diet: (Check all that apply)

_____NPO _____ House _____ Diabetic _____Lactose Free _____GERD

_____ No Seeds _____ Other, please specify:

Tube Feeding Orders: Time of Feeding: _____

_____G-Tube _____ J-Tube

_____Bolus _____ Gravity _____ Pump: Pump Type_____ Rate_____

Formula Type & Amount:_____

Flush with water- time & amount: _____

Food Consistencies (please check only one):

_____ **Regular Diet**- individual is able to cut their own food, no choking or aspiration risks

_____ **Assisted Regular Diet**- needs assistance to cut food, no choking or aspiration risks

_____ **Quarter-size Regular Diet-** staff must cut food prior to serving- food is less than one inch diameter, no choking or aspiration risks.

_____**Dime-size Regular Diet**- staff must cut food prior to serving- food is cut to ½-3/4inch diameter

_____**Quarter-size Soft Diet**- food is of soft/moist consistency requires some chewing, less than one inch in diameter. May add liquid to moisten.

_____ **Dime-size Soft Diet**- food is of soft/moist consistency, requires some chewing, cut to 1/2-3/4 inch in diameter. May add liquid to moisten.

_____**Mechanically Chopped Soft Diet**- Food processor is used, check to ensure no large chunks, moist consistency, chopped to less than ½ inch diameter (Smaller than a raisin) and may add liquid to moisten.

_____**Fine/Ground Soft Diet**- Food processor used longer, crumbly/moist consistency, ground to less than 1/4-1/8 inch (size of rice or smaller), ensure no chunks, and will likely add liquid to moisten.

_____ **Pureed, Pudding-Like Diet-** Food processor used, smooth, pudding-like, very moist consistency, ensure no chunks, strainer can be used, likely need to add liquid to moisten.

Liquid Consistencies (Check one from Column):

_____Thin/Regular Consistency

_____Nectar Thick Consistency

_____Honey Thick Consistency

_____ Spoon-thick/Pudding-Thick Consistency

Fluid Restrictions: _____Yes/amount ____No

Fluid Minimums: _____amount/day

Aspiration Precautions: ____Yes _____No
Specific Instructions:

Food Allergies:

_____ _____ _____

Physician's Name Printed **Signature** **Date**

Medically Necessary Assistive Devices Order Sheet

Client's Name: _____ Date of Birth: _____

Medical Diagnosis Requiring Use of Device: _____

Reason for Ambulatory Devices: _____

Cane:
- ❑ To be used for *all* ambulation
- ❑ Only to be used when:_____
- ❑ Standard Care ❑ Quad Cane

Walker:
- ❑ To be used for *all* ambulation
- ❑ Only to be used when:_____
- ❑ Standard Walker ❑ Wheeled Walker

Wheelchair:
- ❑ To be used for *all* ambulation
- ❑ Only to be used when:_____

Reason For Postural /Orthopedic Support Devices: _____

Use with Wheelchair:
- ❑ Lap Belt ❑ Chest Straps ❑ Head Rest
- ❑ Abductor Pillow ❑ Wedges: Location(s):_____
- ❑ Tray Table

Above to be used:
- ❑ Always when in Wheelchair
- ❑ During vehicle transportation only.
- ❑ When not at a table
- ❑ To Aid Client during activities only.
- ❑ Other:_____

Other: (please specify body parts, use, & parameters)
- ❑ AFO Type:_____ Location: _____ Other:_____
- ❑ Prosthetic Device Type:_____ Location: _____ Other: _____
- ❑ Spinal Brace Type: _____ When: _____ Other: _____
- ❑ Any Other Orthopedic Support Devices:_____

Reason for Medical/Safety Assistive Devices: _____

Helmet:
- ❑ Always ❑ During Transfers Only
- ❑ During Vehicle Transportation Only ❑ During Seizure Activity Only
- ❑ Other Specification: _____

Vagel Nerve Stimulator:
- ❑ Immediately after seizure activity is recognized
- ❑ Other Specification: _____

Any Other:
- ❑ Specification: _____

_____ _____
Practioner's Name (Printed) Signature

_____ _____
DEA # Date

_____
Office Address

_____ _____
Office Phone Number Office Fax Number