LA CASA ADULT DAY HEALTH CENTER, INC
909 Blanco Circle # B Salinas, CA 93901
Ph. (831) 998-8130 | Fax (831) 676-0189

MEDICAL INFORMATION/AUTHORIZATION REQUEST

Participant: _____

Address: _____

Telephone: (____) _____ Age: _____ DOB ____/____/_____ M F

Doctor Office ONLY

Please Attach Copy of Current Health Record and Medical Assessment

Please include ICD-10 Codes

Weight: _____ Height: _____ Heart Rate: _____

Blood Pressure: _____ B.S: _____

La Casa checks Vital Signs weekly: Notify M.D. for the following parameters (including frequency):

* B.S. ≥ 350mgm/dl. or ≤ 60mgm/dl. _____
*B.P ≥ 160/90mmHg. or ≤ 90/50mmHg. _____
*Pulse ≥ 110BPM or ≤ 58BPM _____
* O2 sats ≤ _____

History of Seizures: ____ Yes _____ No History of Falls: _____Yes ____ No

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Blood Glucose Check: ___Yes ____ No (Noon only while at La Casa ADHC and PRN)

Allergies: _____ **NKA_____**

Are There Any Infectious Diseases? _____Yes ____ No
If yes, specify: _____

Diet: La Casa provides a low fat and low sodium diet. Please check box, if participant requires other than a Regular Diet **(Please Circle Diet).**

Regular Diet
Diabetic Diet (45-60 grams carbohydrate/meal)
Renal Diet: Yes No
Fluid Restrictions: ____ Yes _____ No / **If Yes:** _____ **/cc Fluid Intake while at La Casa**
Consistency: (Circle if apply)
Chopped Pureed Liquids: (Circle One) **Thickened Nectar Honey Pudding**

Doctor Office ONLY

Tuberculosis Screening

All participants in Adult Day Health Care Programs must show evidence of **CURRENT Tuberculosis Screening** within the **last twelve months**. Please provide a copy of the screening results with this authorization. **If patient does not have a TB, please administer due to being a requirement prior to enrollment to La Casa Adult Day Health Center.**

Date of Last P.P.D. _____ or Date of Last Chest X-Ray: _____

Results: _____

PLEASE PROVIDE COPY OF CURRENT MEDICATION LIST

Please Print Clearly for Med-Cal. **Fill out by Doctor Office ONLY)**

All Current Medications:	Dosage and Frequency:	Diagnosis:	ICD-10 Code:

(Please attach current medication list)

Participant is able to self administer own medication? Yes No

Physician Name (Print): _____

Address: _____

Phone Number: (____) _____ Fax Number (____) _____

Physician Signature: _____ Date: _____

Participant Name: _____ DOB _____