Golden State Community-Based Adult Services
738 La Playa Street
San Francisco, Ca 94121
Phone: (415) 387-2750 Fax: (415) 387-2712

HEALTH RECORD

PARTICIPANT NAME:_____ **DATE:**_____

DOB:_____ **Medi-Cal ID#**_____ **Phone:**_____

SIGNIFICANT MEDICAL HISTORY AND EXAMINATION:

General:_____ **Cardiac:**_____

HEENT:_____ **Abdomen:**_____

Mouth:_____ **Genital:**_____

Breast:_____ **Rectal:**_____

Lungs:_____ **Musculoskeletal:**_____

Neuro:_____ **Lymphatic:**_____

PROGNOSIS:_____ **Ambulation: cane, walker, wheelchair, no devise**

PRIMARY DIAGNOSIS:	**SECONDARY DIAGNOSIS**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**

MEDICATIONS: (Please indicate dose & frequency)

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Participant is able to administer own meds? ☐ **Yes** ☐ **No**

ALLERGIES:_____

TB CLEARANCE: **PPD Test** ❒ **Positive** ❒ **Negative**

or **Chest X-Ray** ❒ **Positive** ❒ **Negative** **Date:**_____

Please list any physical restrictions: _____

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EMERGENCY PARAMETERS:

Please notify MD if: **BG >** _____**mg/dl or <**_____**mg/dl**

BP > _____**mm/Hg or <**_____**mm/Hg**

I specify BG/BP monitoring on this patient:

BG Monitoring: _____ **X per week**

BP Monitoring: _____ **X per week**

SPECIAL DISCIPLINES NEEDED: Please check all that apply. In order to qualify for program, nursing, physical therapy and occupational therapy evaluations must be conducted.

NURSING	**___Eval & Treatment as specified**
PHYSICAL THERAPY	**___Eval & Treatment as specified**
OCCUPATIONAL THERAPY	**___Eval & Treatment as specified**
SPEECH THERAPY	**___Eval & Treatment as specified**
Psychiatrist/LCSW	**___Eval & Treatment as specified**

Additional Services:

Skilled OT **YES__ NO ____PRN___**

Skilled PT **YES__ NO ____PRN-------**

DIET: (*Please check one*)

- ☐ ***Regular***
- ☐ ***Cardiac Diet*** **(Low salt, Low fat, Low Chol)**
- ☐ ***Diabetic*** – Same a*s Regular* but carbohydrates replaced wit**h low glycemic carbohydrates**
- ☐ ***Renal* - S**ame as *Regular* but with controlled or low **(please circle):**

Low protein Low potassium Low phosphate Other _____

Participant may have a regular diet on special occasions, while at Center: ☐ Yes ☐ No

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PARTICIPANT NAME:_____

I approve my patient attending Golden State CBAS: ☐ Yes ☐ No

☐ **The individual meets all CBAS eligibility and medical necessity criteria and one or more of the following CBAS medical criteria categories :**

- ☐ **Category 1: Nursing Facility Level A (NF-A) or above**
- ☐ **Category 2: Organic, acquired or traumatic brain injury and /or chronic mental disorder**
- ☐ **Category 3: Alzheimer's disease or other dementias at moderate to severe level**
- ☐ **Category 4: Mild Cognitive impairment including Alzheimer's disease or other dementias**
- ☐ **Category 5: Individuals who have developmental disabilities**

There are no medical contraindications for transit time to CBAS in excess of one hour. ☐ **Yes** ☐ **No**

Signature of Treating Physician:_____**Printed Name:**_____

Address:_____ **Phone:**_____**Fax:**_____

License#:_____ **Date:**_____