DUPAGE CARE CENTER ADMISSION HISTORY AND PHYSICAL FORM

To the Physician completing this medical information; you are being presented this form for completion in reference to an application for admission to the DuPage Care Center by a patient of yours. We are a Skilled Nursing Facility providing Post-Acute Rehabilitation, Standard Custodial Care and Alzheimer's Special Care. Please complete this form to assist us in assessing the applicants need for nursing home placement. If you have seen the applicant within 90 days of today's date and would like to send us your dictated History & Physical, Medication List, Test Results and Labs in lieu of this form, we are pleased to accept this information.

Your assistance with this information is greatly appreciated. Please feel free to contact us if you have any questions or would like us to send you this form electronically.

Respectfully,
The DuPage Care Center Admissions Team
Office: (630) 784-4315 Fax: (630) 784-4319

NAME: ___________________________ **DATE**:___/___/___ **Age**______ **Sex**_____ **Race** _____

REASON FOR ADMISSION

____

____

PAST MEDICAL HISTORY

Chronic Illnesses

____

____

Prior Surgeries

____

CURRENT MEDS (include OTC, dx.'s, dosing info.)

____

____

____

____

____

____

____

Allergies:____

HABITS: NO | YES AMOUNT

ETOH____________

SMOKE___________

CHEW TAB_______

OTHER____________________

VACCINES:

PNEUMOVAX __________

FLU________ Hx TB _________

TET TOX______ RX_______

ROS:

Confused Forgetful Visual Impair Constipation Dizziness Fatigue
Depression Dental Resp Difficluty Hearing Impair Falls Edema
Bowel Incont Bladder Incont At Risk to Wander

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PHYSICAL EXAM: WT_____ HEIGHT_______ BP___/___ TEMP_____ HR____ RESP ____

GEN______________________________ HEAD________________EYES_________________

EARS_____________________________ NOSE_______________________________________

FACE_____________________________ THROAT_____________ MOUTH______________

NECK_____________________________ THYROID ___________________________________

BREAST____

CHEST____________________________ CARD_______________________________________

ABDOMEN____

MUS/SKE____

GU_______________________________ RECTAL_____________________________________

SKIN____

EXT______________________________ BACK_______________________________________

NEURO____________________________ MOTOR______________________________________

CEREBELLAR ______________________ SENSORY____________________________________

CN's:____

PROBLEM LIST **RECOMMENDATIONS :**

1) ______________________________ ____

2) ______________________________ ____

3) ______________________________ ____

Based on my assessment of this patient's mental status...

He/She is competent to understand his/her medical condition and patient's bill of rights as presented by the staff.

He/She is currently competent, but has a history of intermittent confusion which may impair understanding.

He/She is not competent to understand his/her medical condition and patient/s bill of rights, therefore the staff is instructed to present this information to a family member, guardian, or conservator.

Signature____

Print Name _______________________________________ Date:___/___/___

This form or other documentation can be mailed to the Admissions Department at the address below or faxed to (630) 784-4319