7121 Old Alexandria Ferry Road
Clinton, MD 20735
Phone: (301) 856-5553
Fax: (301) 856-5512

5400 Norfield Road
Capitol Heights, MD 20743
Phone: (301) 736-6622
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PHYSICIAN'S ASSESSMENT AND INITIAL ORDER FORM

Date: ______ / ______ /______

Patient Name ____ Date of Birth ______ / ______ /______

Baseline Data: Weight: ______ Height: ______ BP: _______ Temp: ______ Pulse: _______ Resp: ______

Primary Diagnosis: ____

Secondary Diagnosis: ____

NUMBER OF DAYS CLIENT MAY ATTEND: 5 4 3 2 (Please circle one)

Significant Past Medical/Surgical History:

System	Normal	Abnormal	History	Present Condition
Cardiovascular System				
Metabolic System				
Respiratory System				
Nervous System				
Endocrine System				
Digestive System				
Reproductive System				
Musculoskeletal System				
Urological System				
Vision				
Hearing				
Other				

PATIENT MUST BE CERTIFIED FREE FROM TUBERCULOSIS

Skin test or Chest x-ray (circle one) Date: ______ / ______ / ______ Result: ______________________

Is the patient free from Infectious Disease? Yes _____ No ______

Is the patient oriented to: Person ______ Place ______ Time ______

Is there memory loss or deficit evident with?

Recent Memory: recall ______ recognition ______

Remote Memory: recall ______ recognition ______

Do any of the following apply?

Depression: Yes ____ No ____ Anxiety Disorder: Yes ____ No ____ Hostility/Combativeness: Yes ____ No ___

Is assistance required with:

ADLs: Yes ____ No ____ Mobility: Yes ____ No ____ Communication: Yes ____ No ____

Assistive Devices: Wheelchair ____ Cane ____ Walker ____

Is patient contenent? Bowel: Yes ______ No ______ Bladder: Yes ______ No ______

Any history of seizures? Yes ______ No ______

RECOMMENDED DIET: Regular ____ Regular, NAS ____ Diabetic ____ Other ____

Page 2 – PHYSICIAN'S ASSESSMENT AND INITIAL ORDER FORM (Cont'd)
Client's Name: ____

KNOWN ALLERGIES: ____

MEDICATION ORDERS:

Medication	Dosage & Frequency	Restrictions	Date Started

Tylenol 2 tabs p o q4h PRN for headache, minor pain or fever above 101 degrees

Other treatments/assessments, i.e., BP monnitoring, dressings, glucose monitoring via finger stick, etc.

Treatment/test	**Frequency**	**Administered by**

May this patient self medicate? Yes _______ No _______
The Center offers a regular exercise program. Specific structured therapies (OT/PT) are available as a supplement to our program. If you wish your patient to receive occupational and/or physical therapies, please attach a physician's order with your detailed intructions. Orders attached: Yes _______ No _______

Date: ______________________________ Signature: ____ M.D.

Doctor, please provide your mailing address and phone number:

Doctor:	**Phone:**	**Fax:**	
Address:	**City:**	**State:**	**Zip:**
Specialty:	**Date last seen:**	**Next Appointment:**	

Current Specialty Providers:

Doctor:	**Phone:**	**Fax:**	
Address:	**City:**	**State:**	**Zip:**
Specialty:	**Date last seen:**	**Next Appointment:**	