3953 Pender Drive, Suite 100
Fairfax, VA 22030
Voice (703) 204-4664
Fax (703) 204-0509
www.InsightMCC.org

INSIGHT MEMORY CARE CENTER

REPORT OF PARTICIPANT PHYSICAL EXAMINATION--ADULT CARE PROGRAM

Examination is to be completed by or under the direction of a licensed physician either within 30 days prior to acceptance for admission or within 30 days prior to admission.

Name of Applicant:________________________________
Applicant Address:________________________________
____
Applicant Phone Number: __________________________
Applicant Date of Birth:__________________________

Print Physician's Name:____________________________
Physician's Address: ______________________________
____
Physician's Phone Number:__________________________
Physician's Fax Number:____________________________

Medical History and Current Status

Present Diagnoses and/or significant medical problems:
____

Other Disabilities: (Please Specify)
____

Allergies & Sensitivities: (inc. medications, food, animal):					
Reactions:					

Code Status (please check one):

☐ Full Code

☐ DNR *(If DNR, please provide signed DNR form.)*

Relevant History

Physical History:__________________________________
Mental History: ___________________________________
Fracture History:__________________________________
Fall History:______________________________________
Recent Surgery:____________________________________
Recent Hospitalization:____________________________
Immunization History: _____________________________
History of Drug Addiction or Excess Alcohol Intake:____________________

Physical Examination: Blood Pressure: _______ Pulse:______ Weight:_______ Height:_______ Temp: _________

Please see attached tuberculosis screening evaluation **(must be dated within 30 days prior to acceptance or admission).**

Signature of Physician:______________________ **Date of Physical**:____________

Recommendations for Care:

MEDICATIONS:

Please complete IMCC's Medication List (enclosed on page 3) for all prescribed and over the counter medications, vitamins, and supplements. ****Insight CANNOT accept printed out medication lists as attachments. All medications must be documented on pg. 3.****

LIMITATIONS:

1. Is this person capable of administering his/her own medications without assistance?

   ☒ No, due to dementia

   ☐ Yes

2. Is this person physically and mentally capable of self-preservation by being able to respond in an emergency to make an exit from the building or to a safe refuge in an emergency without assistance of another person, even if he/she may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command?

   ☒ No, due to dementia

   ☐ Yes

3. Does this person have any restrictions/limitations on physical activities or program participation?

   ☒ No

   ☐ Yes (**indicate type** of restrictions/limitations): ____

DIET:

☐ Regular ☐ Controlled Carbohydrates ☐ Mechanical Soft ☐ Pureed

☐ Other: ____

Special diet or any food intolerances: ____

Please list any nutritional supplements (**Ensure, Glucerna, etc**.) on attached Medication List.

THERAPY :

List therapy (-ies), treatments or procedures the patient is undergoing or should receive and by whom:

None

Other: ____

Signature of Physician:_________________________ **Date of Physical**:___________________

Participant Name: ___________________________ DOB: _________________

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Medication List

All prescription medication, nutritional or other supplements, OTC medications, and vitamins MUST be completed ON THIS FORM (in the chart below). **Insight CANNOT accept “see attached” lists.**

Name of Medication	Dosage	Route	Frequency of Administration	Meds Given at Home or Center (Circle)	Diagnosis
Example: Tylenol	*325mg*	*PO*	*2 Tabs Q6H PRN*	*Home [✓ Center]*	*Headache*
Example: Ibuprofen	*200mg*	*PO*	*2 Tabs BID – 1pm Dose Given at Center*	*Home [✓ Center]*	*Shoulder Pain*
				☐ Home ☐ Center	
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Discontinue ALL PRIOR ORDERS as this is a current and updated set of orders effective the date indicated below.					

Signature of Physician:______________________________ **Date of Physical**:_____________________

**********Since a Physician’s Order is required for medication or treatment at the Center, please sign the above.**********

Virginia Tuberculosis (TB) Screening and Risk Assessment Tool

For use in individuals 6 years and older

Use this tool to identify asymptomatic **individuals 6 years and older** for latent TB infection (LTBI) testing.

- The symptom screen and risk factor assessment may be conducted by a licensed healthcare provider (MD, PA, NP, RN, LPN). If a symptom or risk factor for TB is identified, further evaluation should also be performed by a licensed healthcare provider (MD, PA, NP, RN, LPN), however an RN or an LPN conducting evaluations must have an order by healthcare personnel with prescriptive authority consistent with Virginia professional practice acts for medicine and nursing.
- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment.
- A negative Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) does not rule out active TB disease.

First screen for TB Symptoms: ☐ None (If no TB symptoms present → Continue with this tool)

☐ Cough ☐ Hemoptysis (coughing up blood) ☐ Fever ☐ Weight Loss ☐ Poor Appetite ☐ Night Sweats ☐ Fatigue

If TB symptoms present → Evaluate for active TB disease

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the risks below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

☐ **Birth, travel, or residence in a country with an elevated TB rate ≥ 3 months**

- Includes countries other than the United States (U.S.), Canada, Australia, New Zealand, or Western and North European countries
- IGRA is preferred over TST for non-U.S.-born persons ≥ 2 years old
- Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism < 3 months may be considered for further screening based on the risk estimated during the evaluation.

☐ **Medical conditions increasing risk for progression to TB disease**

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunoileal bypass, solid organ transplant, head and neck cancer

☐ **Immunosuppression, current or planned**

HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact to someone with infectious TB disease at any time**

☐ **None; no TB testing indicated at this time**

Patient Name ____________________________ Date of Birth ______ /______ /______

Name of Person Completing Assessment _________________________ Signature of Person Completing Assessment __________________________

Title/Credentials of Person Completing Assessment __________________________ Assessment Date ______ /______ /______

Adapted from California Tuberculosis Risk Assessment (www.ctca.org) & Colorado Tuberculosis Risk Assessment (www.colorado.gov) VDH TB 03/2023