Behavioral Health Specialists

Admission Medical History & Physical
Medication Reconciliation

☐ **Sunrise Place**
1900 Vicki Lane
Norfolk, NE 68701
Ph: (402) 379-0040 Fax: (402) 379-0759

☐ **Seekers of Serenity**
4432 Sunrise Place
Columbus, NE 68601
Ph: (402)564-9994 Fax: (402)562-6458

Name:			Date of Birth:
Address at time of admission:			
Primary Physician:			
Address:		Phone:	Fax:
Primary Pharmacy:			
Address:		Phone:	Fax:
Name of Facility completing Admission Physical:			
Address:		Phone:	Fax:
INSURANCE INFORMATION – MUST bring a copy of insurance card at time of admission			
Name of Policy:	Name of policy holder:		
Policy Number:	Phone:		Fax:

Past Medical History (to be completed by Client)	
Head / Neurological	**Y / N** Poor vision **Last eye exam**: ______________ **Y / N** Headaches **Y / N** Seizures **Y / N** Hearing problem **Y / N** Ear Problems **Y / N** Dental pain: ____________________ **Date of last exam:** ____________ **Y / N** Recent head injury with loss of consciousness (Date:__________)
Bone Joint Muscles	**Y / N** Recent injuries with ongoing pain/limited function (List: ____________________________ ____________________) **Y / N** Arthritis / Osteoporosis – treatment (list):____________________ **Y / N** Other chronic Pain: ____________________ **Y / N** Limited mobility – List: ____________________
Heart	**Y / N** High Blood Pressure **Y / N** History of Heart Attack **Y / N** Palpitations **Y/ N** Other heart disease– List: ____________________
Stomach / Bowel	**Y / N** -Heartburn **Y / N** - Ulcers **Y / N** - Constipation **Y / N** - Diarrhea Other – List: ____________________
Respiratory	**Y / N** Smoker: Pk/day: _______ Age started:__________ **Y / N** Asthma **Y / N** Emphysema/COPD
Mental Health / Substance Abuse	Previous Mental Health treatment: ____________________ ____________________ **Y / N** Previous Substance Abuse treatment: (List where / when) ____________________ Drug(s) of choice (list): 1)____________________ Date/amt last used: ____________________ 2)____________________ Date/amt last used: ____________________ 3)____________________ Date/amt last used:____________________ **Y / N** History of seizures with withdrawal **Y/ N** History of hallucinations / delusions with use or withdrawal

Infectious Disease	**Y / N** Hepatitis B / C: Tested: **Y / N** Results: ______________________________ **Y / N** HIV: Tested: **Y / N** Results: ______________________________ **Y / N** I have been vaccinated for Hepatitis B Tetanus: Last Tetanus shot: ___________ Tuberculosis: Last Tested: ___________ **Y / N** Sexually Transmitted diseases (List): ______________________________ **Y / N** MRSA infection (current-list)______________________________ **Y / N** I am currently sick and/or being treated for an infectious illness If yes what: ______________________________
Nutritional	**Y / N** Special Diet: ______________________________ **Y / N** Difficulty chewing or swallowing **Y / N** Diabetic: Treatment List: ______________________________
OB / Gyn	**Y / N** Currently Pregnant Due Date: ___________ **Y / N** Currently Breast-feeding **Y / N** Currently treated for gynecologic condition: ______________________________
Allergies	**Environmental:** ______________________________ **Foods:** ______________________________ **Medications:** ______________________________ ______________________________
Medications	I take the following prescribed medications on a regular basis: **Medication:**______________________________ **for:** ______________ **Medication:** ______________________________ **for:** ______________ **Medication:** ______________________________ **for:** ______________ **Medication:** ______________________________ **for:** ______________ **Medication:** ______________________________ **for:** ______________ I take the following over-the-counter medications on a regular basis: **Medication:**______________________________ **for:** ______________ **Medication:** ______________________________ **for:** ______________ **Medication:** ______________________________ **for:** ______________ **Medication:** ______________________________ **for:** ______________ **(All medications must be listed on the Medication Reconciliation and you must bring a 30 day supply with 1 refill available ON ADMISSION)**
Other (Continue on addnl paper as needed)	List all other medical conditions not mentioned above, for which you have been treated in the last year: Condition / Treatment: ______________________________ Treating Practitioner: ______________________________ Condition / Treatment: ______________________________ Treating Practitioner: ______________________________ Condition / Treatment: ______________________________ Treating Practitioner: ______________________________

This information is complete / accurate to the best of my knowledge:

Client Signature: ______________________________ Date: ______________

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Client Name: ____ Date: ______________

Physician's Report

Temp: _______ Pulse: ________ Respiration: ________ B/P: ________ Ht: ________ Wt: _________

Hearing: ____

Constitutional: *Cooperative / Uncooperative* Distress: *None / Mild / Moderate / Severe*

Review of systems: ☐ See Clinic EMR report (attached)

☐ B/P is stable below 150/90

☐ Pulse rate is below 120

Current Detox Symptoms: ____

____

Any Anticipated Detox Symptoms after admit: ____

____

Detox medications indicated: ☐ No ☐ Yes: (List):____

(Detox meds must be brought with client on admission – Call facility for instructions if concerns and supply needs to be delivered)

Overview/Review of Systems: (List any noteworthy conditions and recommendations for management during STR treatment)

____

____

____

Recommendations:

☐ Client is medically stable and able to participate in residential drug / alcohol treatment

☐ Restrictions: ____

____

____

☐ Physical Therapy Assessment/Referral:____

____

COMPLETE MEDICATION RECONCILIATION ON NEXT PAGE:

____ ______________________

(Practitioner's signature) (Date)

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Client Name: ___________________________DOB:___________ Date: __________________

Allergies: ____

All medications **including OTC medications** brought into SOS/SRP must be listed and by the Practitioner completing this H&P. A current 30-day supply of medications and available refill is **REQUIRED** for admission.
* Attached EMR medication list is approved ____.
(Provider's Signature)

***Please be sure any EMR records are complete and signed by the provider. Any additional orders must be written above. Clients can NOT be admitted without this reconciliation and a 30 day supply with refills available. Thank You.**

Medication / Strength	Directions	Diagnosis (report of need)

Physician: Signature: ____ Date: __________