Adult Day Activities

Provider Referral Packet

Avenue 360's Adult Day Activities program provides a safe and inclusive environment for people living with HIV who need support during the day. The program provides daytime services for up to 10 hours per day to address medical, physical, mental, and social needs. Medical referral required.

The program provides:

- Nutritious meals and snacks
- Nutrition counseling
- Medication administration
- Nursing services
- Occupational therapy
- Social activities
- A place to rest, shower and do laundry if needed

Does the patient meet the medical criteria (PLWH) and has registered through CPCDMS?

☐ Yes ☐ No

Patient name: _____

Patient DOB: _____

Patient phone number: _____

Provider name: Provider signature:	Date:

Please attach copy of patient's problem list, medication list, most recent labs, and sign section VI on form 3055.

TEXAS
Department of Aging and Disability Services

Form 3055
October 2015-E

Day Activity and Health Services (DAHS)

Physician's Orders

Day Activity and Health Services (DAHS) is a licensed day care program for the aged and/or disabled administered by the Texas Department of Aging and Disability Services. The program provider must have services available for eligible individuals at least 10 hours per day, Monday through Friday, except holidays. Services include licensed nursing care, planned activities, hot lunch and mid-morning/afternoon snacks, personal care assistance, transportation to and from the facility, therapies and treatments.

Section I. Individual Information

Individual Name (Last, First, Middle Initial)	Date of Birth	Individual No.
DAHS Facility Name AVENUE 360 HEALTH & WELLNESS DAY ACTIVITY CTR.	DAHS Nurse CYNTHIA CONNOR, LVN	DAHS Area Code and Telephone No. 281-552-8610
DAHS Facility Address (Street, City, State and ZIP Code) 2920 Fannin St. Houston, Texas 77002		

Section II. List Chronic Medical Diagnoses from the Last 24 Months

Section III. Functional Limitations Related to Medical Diagnoses

☐ Behavior/Emotional Problems	☐ Dizziness	☐ Difficulty Swallowing	☐ Limited Range of Motion
☐ Contractors	☐ Hearing Impairment	☐ Limited Dexterity	☐ Uses Ambulation Device
☐ Incontinence	☐ Nausea	☐ Hearing Impairment	☐ Paralysis
☐ Spasticity	☐ Shortness of Breath	☐ Tremors	☐ Numbness
☐ Pain	☐ Vision Impairment	☐ Unable to Stand for Long	☐ General Weakness
☐ Blackouts	☐ Falls Easily	☐ Cognitive Impairment	

☐ Other: _____

Section IV. Special Diet

Instructions/Notes/Comments:

Individual Name (Last, First, Middle Initial)	Date of Birth

Section V. Medications and Treatments

To provide better emergency care, list all known medications taken; not only those prescribed by this office, such as Prescribed/PRN/OTC.

Medications

Medication	Dosage	Route	Frequency	Location of Medication Administration: Home	Location of Medication Administration: DAHS	Initial	Date
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
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				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		

Therapies or treatments performed at DAHS, including monitoring tasks, specific interventions or procedures.

Ordered Treatments/Monitoring/Intervention	Frequency	Notes/Comments

Section VI. Physician's Certification

I certify this individual has a chronic medical diagnosis other than an intellectual and developmental disability or mental health condition and a functional limitation, and hereby order the above care, monitoring or intervention by a licensed nurse to be performed at the DAHS facility.

I also certify that I am not a significant owner, partner or member of the service provider requesting this order for DAHS.

Signature – Physician	Today's Date	Date of Verbal Order (if app.)	End Date (if order is time limited)

Physician's Name (Type or Print)	MD ☐	DO ☐	License No./NPI	State	Military or VA ☐ Yes ☐ No

Physician's Address (Street, City, State, and ZIP Code)	Area Code and Telephone No.