

F A X S H E E T

Date: 09/04/2025 01:54:38 AM
To:
Subject: Patient Document
Fax Number: 702-648-1408
To Company:
From Name: Ballesteros, Giselle
From Company: CENTERWELL-WEST CHARLESTON
From Facility: CENTERWELL-WEST CHARLESTON
Support Contact:
Number of Pages(s): 9

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Adult Day Care Center of Las Vegas
901 N. Jones Boulevard
Las Vegas, NV 89108
702.648.3425
Fax: 702.648.1408



Adult Day Care Center of Henderson
1201 Nevada State Drive
Henderson, NV 89002
702.368.2273
Fax: 702.243.2273

PHYSICIAN ORDERS

Patient's Name Barbara Grigsby Date of Birth 03.19.1943

This client may have the following at Adult day Care Centers of Las Vegas and Henderson (Please check all that apply.)

- Acetaminophen 500 mg 1-2 tabs every 4 hours prn pain. Not to exceed 3000 mg in 24 hours.
- Maalox antacid suspension 30 cc up to 4 times daily prn acid indigestion, heartburn, gastric discomfort.
- Bismuth subsalicylate 30 cc every hour prn gastric discomfort, nausea.
- Antibiotic ointment with dry sterile dressing prn minor skin wound. Notify physician if no improvement after 7 days.
- Nevada Senior Services Nursing staff may administer 2-step Tb test upon new admissions and 1 step annually thereafter.
- OT Eval and treatment as needed.

[Signature] Physician Signature 8/26/2025 Date

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901 N. Jones Boulevard
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(702) 648-3425
Email

NURSING@NEVADASENIORSERVICES.ORG



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07/15/2025

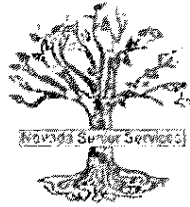
To the caregiver of: Barbara Grigsby

Barbar is due for her Annual physical & /TB test. Her physical is due by 8/27/2025. Barbara needs this physical & TB test completed by 8/22/25. If unable to have physical &TB test completed, Barbara may be required not to attend until the physical and TB test are completed due to our protocol guide lines. Please email physical when completed to the nursing email above. We appreciate your promptness with this matter.

Thank you,

Nursing Staff

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MEDICAL EVALUATION
 (MUST BE FILLED IN BY PHYSICIAN)

Date of Request: 8 / 27 / 25 Request Type Initial/New Continuing Revised

NOTES

SECTION I: RECIPIENT INFORMATION

Recipient Name: Barbara Grigsby Date of Birth: 03-19-1948
 Recipient Medicaid ID: J Phone: 702-348-6270
 Mailing Address: 3629 Willow Springs drive
 Current Residence: Independent Living Group Care/Assisted Living Other

SECTION II: ADHC FACILITY INFORMATION

Name: Adult Day Care Center of Las Vegas NPI: 1821431032
 Phone: 702-648-3425 FAX: 702-648-1408
 Physical Address: 901 N. Jones Blvd., Las Vegas NV 89108
 Name and professional title of the person completing sections I, II, III of this Form
 Name: Les Jacobs Title: CFO
 Contact Phone: 702-648-3425 Contact Fax: 702-648-1408

SECTION III: REQUESTED SERVICE

Requested Begin Date of Service: 8/2025 Requested End Date of Service
 (Must be last day of Month): 8-31-2026
 Requested number of days per week: 5 Total Units Requested: ICD-10 Code: F
 Choose One: S5102 (Attends 6 or more hours per day S5100 (Attends less than 6 hours per day) or varies
 between less than and more than 6 hours per day

SECTION IV: RECIPIENT VERIFICATION AND SIGNATURE

I am choosing to attend an Adult Day Health Care facility. If there is more than one facility in my area, I verify that I have been offered a choice of facilities.
 I, or my legal representative, was involved in the formulation of the service plan.

Recipient Signature: Barbara Ann Grigsby Date: 8/27/24

SECTION V: UNIVERSAL NEEDS ASSESSMENT I PHYSICIAN, PRN OR PA EVALUATION Note to physician's office: Unless instructed to do otherwise, please return this form to the facility or to the patient and/or care provider.

Date of Examination: 08/22/2024 Assessor Name: Rosemarie Carandany

Address of Assessor: 4001 S. Decatur Blvd Las Vegas NV 89103

Contact Phone: 725-224-6967 FAX Number: 833-749-0359 NPI: 1821431032

Assessor is a (check one) Physician Advanced Practice Registered Nurse Physician's Assistant
 Assessor's State Board Medical or Nursing or Medical Examiner License Number: _____

Recipient's Vital Signs: Blood Pressure 108/77 Pulse: 73 Respirations: 18 Temperature: 97.9
 Recipient's Height 63 inches Recipient's Weight 156 lbs

Tuberculosis (TB) Screening: TB testing is annually. The initial test must be 2-step or the 1-step Quantiferon Gold. For continued services the annual test may be 2-step or either of the single test options. (See Nevada Administrative Code (NAC) 441A.380 and NRS 441A.120)

Option 1: 2-Step TB Skin Test: Yes No

TB Skin Test First Step
 Arm Used: _____ Date/Time Given: _____ Date/Time Read: _____
 Given By: _____ Read By: _____ Results: _____

TB Skin Test Second Step
 Arm Used: _____ Date/Time Given: _____ Date/Time Read: _____
 Given By: _____ Read By: _____ Results: _____

Enter the Lot # and Expiration Date if the TB testing was done in the physician's office:
 Lot #: _____ Expiration Date: _____
 Lot #: _____ Expiration Date: _____

Option 2: QuantiFERON Gold: Yes No
 Test Date: 8/22/2024 Date Read: 8/25/2024 Results: NEGATIVE

Option 3: If the recipient has had a positive TB skin test, complete the following:
 Chest X-Ray (only if patient has not had a previous chest x-ray after a Positive skin test):
 Date: _____ Results: _____

Signs and Symptoms Checklist: (to be completed annually for a recipient after a positive TB skin test has been documented.)
 Date of Screening: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No Cough testing three or more weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No Unexplained weight loss
<input type="checkbox"/> Yes <input type="checkbox"/> No Anorexia (loss of appetite)	<input type="checkbox"/> Yes <input type="checkbox"/> No Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue
<input type="checkbox"/> Yes <input type="checkbox"/> No Coughing up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No BCG Vaccine

Fall Risk:
 Has the client fallen in the past six months? Yes No
 Specify: Patient use Walker

Does this patient have any infectious diseases? Yes No
 Specify: _____

Nutritional Needs/Special Diet: Yes No
 Specify: _____
Allergies: No Food Medication
 Specify: _____

Physician Orders (examples include Durable Medical Equipment, Physical Therapy, Occupational Therapy, Speech Therapy, Special Diet, etc.) Occupational Therapy Evaluate/Treat: ADL / IADL Retraining Home Assessment Wheelchair Assessment Frequency & Duration: Therapist Discretion Treatment Goals As Per Therapist Discretion Unless Otherwise Noted Above -- Patient needs Occupational Therapy evaluation/assessment
 Physician's Initial: _____

Medical History
 Diagnosis: Schizoaffective disorder
 History / Physical: Blind left eye

Medications
 List all medications patient is taken, include medication name, route, dosage, time of day, date last dispensed, and reason for taking. (Attach separate page if needed).
Meds lists Attached

Clinical Information (check all applicable boxes to indicate substantial impairments, risk factors and needs)
Treatment / Special Needs (check all that pertain and explain below):
 Trach Suctioning O2 Colostomy External Catheter PICC Saline-Lock
 Feeding Tube (G-tube, J-tube, NG Tube) Wound Care Glucose Monitoring Insulin Dependent
 Medication Management Nebulizer Treatment Foley Catheter Vital Signs / Blood Pressure Monitoring Other _____
 For all items checked above, indicate who performs it, frequency, duration, location of wound and specific treatments:

Substance Abuse: Yes No (This individual has been diagnosed with a substance abuse problem that will be addressed at the ADHC facility and that primarily contributes to his/her need for the ADHC services)

Multiple Social Service System Involvement: Yes No (This individual is involved in multiple social service systems (e.g., criminal justice system or welfare systems) OR multiple case managers from various public and/or community organization and multi-system agencies related to the recipient's unmet needs.)

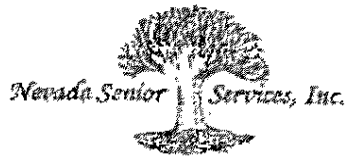
Activities of Daily Living: (Check all activities with which recipient needs assistance and add applicable comments)
 Dressing Eating Hygiene Bathing Mobility Transfer Bladder Bowel Grooming
 Comments: Uses Walker Can walk independently.

Need for Supervision: (Check all boxes that pertain)
 Wandering Resists Care Socially Inappropriate Verbally Abusive Behavior Problem
 Safety Risk Physically Abusive Visually Impaired Hearing Impaired

Cognitive Behavior: (Check all boxes that pertain)
 Speech/Language/Communication Self-Direction Social Development Learning
 Vocational Development Maladaptive Behavior Psychosis/Hallucinations Mild Memory Loss
 Moderate Memory Loss

PHYSICIAN, APRN OR PA VERIFICATION AND SIGNATURE see next page

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DATE OF REQUEST: F, 15, 25 REQUEST TYPE: Initial/New Continuing Revised

NOTES:

SECTION I: RECIPIENT INFORMATION

Recipient Name: Barbara Grigsby Date of Birth: 3-19-1943
 Recipient Medicaid ID: _____ Phone: _____
 Mailing Address: _____
 Current Residence: Independent Living Group Care/Assisted Living Other: Family

SECTION II: ADHC FACILITY INFORMATION

Name: Afiya Kambon NPI: _____
 Phone: 702.333.1533 Fax: 702.648.1408
 Physical Address: 901 N. Jones Blvd. Las Vegas, NV 89108
 Name and professional title of person completing sections I, II and III of this form:
 Name: Afiya Kambon Title: Senior Client Service Representative
 Contact Phone: 702.333.1533 Contact Fax: 702.648.1408

SECTION III: REQUESTED SERVICES

Requested begin date of service: N/A Requested end date of service: N/A
 (Must be last day of the month)
 Requested number of days per week: _____ Total Units Requested: _____ ICD-10 Code: _____
 Choose one: S5102 (Attends 6 or more hours per day) S5100 (Attends less than 6 hours per day or schedule varies between less than or more than 6 hours per day)

SECTION IV: RECIPIENT VERIFICATION AND SIGNATURE

I am choosing to attend an Adult Day Health Care facility. If there is more than one facility in my area, I verify that I have been offered a choice of facilities.
 I, or my legal representative, was involved in the formulation of the service plan.
 Recipient Signature: X Date: _____