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

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

Nevada Senior Services

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.

Physician Signature 8/26/2025 Date

Adult Day Care Center of Las Vegas
901 N. Jones Boulevard
Las Vegas, NV 89108
(702) 648-3425
Email
NURSING@NEVADASENIORSERVICES.ORG

Adult Day Care Center of Henderson
1201 Nevada State Drive
Henderson, NV 89002
(702)368--2273
FAX: (702) 243-2273

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: 03-19-1943
Recipient Medicaid ID:	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 For	
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 1 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 Carandang

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: _____

☐ Yes ☐ No Cough testing three or more weeks ☐ Yes ☐ No Unexplained weight loss

☐ Yes ☐ No Anorexia (loss of appetite) ☐ Yes ☐ No Fever

☐ Yes ☐ No Night sweats ☐ Yes ☐ No Fatigue

☐ Yes ☐ No Coughing up blood ☐ Yes ☐ 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 would 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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702.368.2273
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DATE OF REQUEST: 7/15/25 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:**

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