Adult Day Medical Model Day Care

Registrant Assessment Instrument

Name _____

Address _____

_____

City County State Zip Code

Phone _____ Social Security # _____

Date of Birth _____ Age _____ Height _____ Weight _____ Gender M F

Referral Source: _____

Name: _____ Phone # _____

RECENT HOSPITALIZATIONS: (LAST 12 MONTHS)

_____

_____

_____

DIAGNOSIS:

_____

_____

_____

ALLERGIES:

_____

HOUSING ARRANGEMENTS

Alone _____ Spouse _____ Child _____ Relative _____ Other _____

OTHER MEMBERS OF HOUSEHOLD

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Private Residence _____ Apt. Low - Rise _____ Apt. Hi - Rise _____

Senior Housing _____ Community Housing _____

MEDICAL INFORMATION - CARE FACTORS

1. Falls _____ 2. Substance Abuse _____
3. Contracture _____ 4. Incontinent Bowel _____
5. Colostomy _____ 6. Incontinent Bladder _____
7. Foley Catheter _____ 8. Hearing Impaired _____
9. Vision Impaired _____ 10. Comm. Deficit _____
11. Receptive Aphasia _____ 12. Expressive Aphasia _____
13. Dementia _____ 14. Speaks English _____
15. Understands English _____ 16. Other Language _____
17. Paralysis (loss of function in extremities) _____
18. Paralysis (total loss of function) _____
19. Other Care Factors _____

Diet _____

Dentures: Upper _____ Lower _____ Full _____ Partial _____ Bridge _____
History of Choking YES NO _____

TREATMENTS (DRESSINGS, IRRIGATIONS, OXYGEN, WOUND CARE, ETC.)

_____

MEDICATIONS

	Name	Dose	Frequency	Reason
1				
2				
3				
4				
5				
6				
7				
8				

Medication Management Self _____ Partial Assist _____ Total Assist _____

PRIMARY PHYSICIAN

Name _____

Address _____

_____

Phone _____

SECONDARY PHYSICIAN

Name _____

Address _____

_____

Phone _____

OPTOMETRIST _____

DENTIST _____

PODIATRIST _____

PSYCHOLOGICAL FACTORS - BEHAVIORAL DEFICITS

1. Verbally Disruptive _____
2. Physically Disruptive _____
3. Socially inappropriate _____
4. Sleep Patter Disturbance _____
5. Emotional Frequency _____
6. Wanders _____
7. Inadequate Social Skills _____
8. Disorientation: Time _____ Place _____ Person _____
9. Impaired Decision Making _____
10. Psychiatric Symptoms _____

ACTIVITIES OF DAILY LIVING S (SELF) P (PARTIAL) T (TOTAL)

1. Transfer _____ 2. Toileting _____
3. Eating _____ 4. Housework _____
5. Finances _____ 6. Laundry _____
7. Appointments _____ 8. Shopping _____
9. Telephone _____ 10. Meal Prep _____

DEPARTMENT OF SOCIAL SERVICE

Contact _____

County _____ Phone _____

NOTE: A copy of the budget sheet will be needed if applicant is on medicaid. If there is a spend down, note the amount:

Spend Down _____

Medicaid Number _____ Medicare A B

Other Insurance _____

NOTE: A copy of the medicaid or insurance card is needed

SOURCES OF INCOME

Social Security _____ Pension _____

VA Pension _____ Rental Income _____

Private Pay Rate _____

NOTE: Private pay needs to pay month deposit, and copy of bank accounts and resources

NOTE: Beauty shop needs to be paid at time of service or to set up a "Resident Account."

EMERGENCY CONTACTS

Name _____

Address _____
Street Apt. Number

_____
City State Zip Code

Relationship _____

Phone (Home) _____ (Work) _____

Name _____

Address _____
Street Apt. Number

_____
City State Zip Code

Relationship _____

Phone (Home) _____ (Work) _____

HOME NURSING SERVICES

Agency Name _____ Phone _____

Frequency: MON TUES WED THURS FRI SAT SUN

Time in Day _____

TRANSPORTATION

Private Car _____ Van (Ambulatory) _____ Van (Wheelchair) _____

Star Bus _____ TAXI _____ Other _____

Home pick up time _____ Program pick up time _____

Potential to stay in the community

GOOD _____ FAIR _____ POOR _____ OTHER _____

Service Utilization	Potential Use	Actual Use
1. Nursing		
2. Physical Therapy		
3. Podiatry		
4. Diagnostic Lab		
5. Nutrition		
6. Occupational Therapy		
7. Dental		
8. Pharmacy		
9. Social Services		
10. Speech Therapy		
11. Recreation		
12. Audiology		
13. Ophthalmology		
14. Other		

FAMILY BACKGROUND

Spouse

Sister/ Brothers

Children

Grandchildren

Religion _____ Occupation _____

Place of Birth _____ Education _____

HOBBIES, INTERESTS, AND FAVORITE ACTIVITIES

_____

_____

REGISTRANT/ FAMILY PROGRAM GOALS FOR EXPECTATIONS

_____

_____

Expectations for Program Services M T W TH F

Admission Committee Date _____

REASON FOR PROGRAM SERVICES

1. Socialization_____
   _____
2. Health care monitoring/ nursing management (treatments, medications, monitoring and supervision, health counseling)_____
   _____
3. Maintain wellness/ delay deteriorization (services offered will maintain of limit decline of registrants health)_____
   _____
4. Respite for informal support (family help in care giving)_____
   _____
5. Case coordination of services (arrange outside services) _____
   _____
6. Reduced psychosocial functioning (registrants learning capabilities are limited or declining – dementia, etc.)_____
   _____
7. Restorative rehabilitation (restore independence or functioning)_____
   _____
8. Maintain rehabilitation_____
   _____
9. Informal support supplement (formal support for registrants who need more services than home or other less formal programs)_____
   _____
10. Personal care services (baths, incontinence, etc.)_____
    _____
11. Congregate setting (program to supplement other services)_____
    _____
12. Other_____
    _____

ADMISSIONS COMMITTEE DECISION, AND ADDITIONAL COMMENTS

NARRATIVE NOTES AND ASSESSMENT

Interviewer _____

Location of Interview _____

Date of Interview _____

Others Present _____

Date Completed _____