For Office Use Only:

Date Received: _____

Transportation:

_____

Adult Day Health Care

Personal Care & Daily Socialization for Your Loved One

Adult Day Health Care: Initial Screening

Name: _____

Address: _____

_____

Living Arrangements: _____(Living alone, with family, within an agency)

Phone Number: _____ DOB: _____

Social Security Number: _____ Primary Language: _____

Medicaid Number: _____ Medicare Number: _____

MLTC/MMC Provider: _____ Provider #: _____

Contact Person/Care Manager: _____Phone #:_____

Email address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Address: _____

Email address: _____

Primary Care Physician:

Facility: _____Physician Name:_____

Address: _____

Phone Number: _____ Fax Number: _____

DNR/MOLST: Yes/No Legal Guardian: Yes/No Health Care Proxy: Yes/No

Please attach these documents if applicable.

Preferred Hospital: _____

Program Interest: Day Program or Evening Program (circle one)

Attendance Days (Circle All that Apply): Monday, Tuesday, Wednesday, Thursday, Friday

Services Needed (Circle All that Apply): PT/OT/Speech

Community Agencies/Services Involved (Name, Agency, Phone Number, Service provided) Please be specific:

_____

_____

_____

Diagnoses/Medical Concerns:

_____

_____

_____

Psychosocial Concerns:

_____

_____

Support Needs:

Diet: _____

Allergies to Food: Yes/No If Yes: _____

Allergies to Medication: Yes/No If Yes: _____

Any swallowing difficulties? Explain: _____

Check all that apply: Put details of care needs in the comment section below.

Mobility: Walker Wheelchair Cane No Device

Eating: None Food Cut Observed Hand Fed Altered Consistency: _____

Bladder: Continent Incontinent **Pads/Briefs:** Yes/No What type: _____

Toileting: None Some Assist Total Assist

Bowel: Continent Incontinent

Transferring Assistance Needed: Is a lift used, 1 person, 2 person assistance? Explain:

_____

_____

Hearing: Within normal limits wears hearing aids Deaf Difficulty hearing in noisy environment

Vision: Within functional limits wears corrective lenses partially impaired vision legally blind

Communication: Verbal Non-Verbal Difficult to understand Communication device

Makes needs known can read/write

Adaptive Equipment Needed (AFO's, walker, brace, utensils, plates):

_____

_____

Covid Vaccination (This is required to attend program): Yes/No **Please provide a copy of vaccination card**

Will person require medications to be administered while at program? Yes/No

If person will require medications to be given by a nurse while at program, be advised that all medications must come into program in a current labeled bottle. The label must have the person's name, medication name, dosage, frequency and route. If the person is self-medicating they must be able to identify the medication, why they are taking it and when they should be taking the medication. All medications must be transported securely and safely.

Comments:_____

_____

_____

_____

_____

_____

If accepted into program, it is required that an initial assessment and care plan is completed. This will occur every 6 months. Is this person able to report medical, social and psychological information independently?

Yes/No Circle one

If they are not able to report independently, who will assist in these assessment times upon admission and every 6 months while enrolled in program services?

_____

_____

Referral Sources: _____ Phone: _____

How did you hear about us?

_____

Thank you for your interest! You can return your referral by fax to 585-341-2413 or by mailing to:

Jewish Senior Life

Attn: Adult Day

2021 Winton Road South

Rochester, NY 14618