**For Office Use Only:**

Days of Attendance:

_____

Arrival/Departure Times:

_____

Adult Day Health Care

**For Office Use Only:**

Date Received: _____

Transportation:

_____

_____

# Adult Day Health Care: Initial Screening

Do not leave anything blank

Date: _____

Name:_____

Address:_____

_____

Phone Number: _____ DOB: _____

Living Arrangements: _____

(living alone, with family, within an agency)

Medicaid Number: _____ Medicare Number:_____

MLTC/MMC Provider:_____ Provider #: _____

Contact Person/Care Manager: _____Phone #:_____

Social Security Number: _____ Primary Language:_____

**Emergency Contact:**

Name: _____ Phone:_____ Relationship:_____

Address: _____

Primary Care Physician: _____

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: _____

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):** Dates received: _____
**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 Source: _____ Phone: _____

How did you hear about us?

_____

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

Jewish Senior Life ADHC

Attn: Adult Day

2021 Winton Road South

Rochester, NY 14618