Adult Program (TLC) @ Mercy School For Special Learning

830 S. Woodward St.
Allentown, PA 18103-3440

Date_____

Part I: Personal Information

Name:
Nickname:
Address, Town, and Zip Code:

Phone:
Height:
Weight:
Eye Color:
Hair Color:
Sex: _____M _____F
Birthdate:
Age:
SS# xxx-xx-
Marital Status:
Spouse's Name:
Identifying Marks:

Responsible Party

Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Financial Responsible Party

Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Emergency Contact #1

Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Emergency Contact #2

Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Part II: Legal Status

Is there any one person authorized to make decisions under a power of attorney or a legal guardian?
If yes, who/relationship:
Do you have a living will or advanced directive?
If yes for either question, we need a copy for our file.

PART III: Referral

How did you hear about the Adult Day Center?

Reason for wanting to attend the Adult Day Center?

If you are determined eligible, how many days per week are you interested in coming to the center? Which Days? Sun Mon Tue Wed Thurs Fri Sat

PART IV: Living Arrangements and Transportation

Living Arrangements: Spouse_____ Child _____ Other, specify _____

Type of Dwelling: House _____ Apartment _____ Other, specify _____ Circle: Lives with someone Lives alone

Present Address:

What transportation you will use to get to and from the Center?

Does the applicant carry a house key? _____ If yes, can applicant be left at home alone? _____

PART V: Family and Social History

Birthplace:

Father's Name: Mother's Name:

Names of living brother and/or sisters:

Names of deceased brothers and/or sisters:

Names of living children:

Names of deceased children:

What was the highest grade in school you completed?

Are you a veteran, spouse of a veteran, parent of a veteran? (Circle one) What branch? _____

What was/is your main occupation? What was your worst job?

Circle activities of potential interest.

Arts and Crafts Physical Games Exercise Plant Care Sensory/Mental Stimulation	Bingo Music/Choir Pet Therapy Read Newspaper or Magazine Bible Study	Cards Table Games Socializing Other: _____

Is applicant comfortable being in the company of non-family members?

_____ What is one of your best skills?

PART VI: Medical Information and Health History

Diagnosis:

Primary Doctor:
Address, Town, and Zip Code:

Phone:

How would you rate your own health?

Current Medical Problems:

Past Medical Problems:

Date of last hospitalization:
Where:
Reason:

Do you have diabetes? How is it controlled? Oral medications? Injection? Diet?

Do you have seizures? _____ If yes, explain:

_____ Are you allergic to

any medications? _____ If yes, explain:

_____ Are you allergic to any

environmental allergens? _____ If yes, explain: _____

Can the applicant self-administer medications?

Medications: Be sure to include over the counter medications.

Medication	Dosage	Time/Frequency

PART VII: Medical Contacts

Other physicians, CRNP (include names and phone number):

Preferred Hospital:

Preferred Medical Transport Company:

PART VIII: Caregiving

What other community agencies (home health or social service) do you currently use or have used?

Agency	Reason

Do you have a care manager?

Are there other caregivers besides the responsible party listed on the front page?
_____ If yes, please list: Relationship:

Limitations, problems, or restraints on primary caregiver?

What is the extent of the perceived burden on the caregiver(s)?

Does the caregiver feel the need for support? If yes, explain:

PART IX: ADLs, IADLs, and Physical Aids

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)

Levels of Assistance: ssary
0 = Independent – Completes task independently
1 = Minimum Assistance – Occasional assistance or supervision may be nece
2 = Moderate Assistance – Assistance or supervision is always needed 3 = Maximum Assistance – Totally Dependent on other

Activity	Ind 0	Min Assist 1	Mod Assist 2	Max Assist 3	Primary Source of Help	Comments
Mobility						
Transferring						
Bathing						
Grooming						
Personal Hygiene						
Eating						
Toilet Use						
Meal Preparation						
Laundry						
Shopping						
Light Housework						

Home Maintenance						
Telephone						
Financial Management						
Transportation						

Medical Devices Used:

Walker Cane Wheelchair O_2
Prosthetics Glasses Hearing Aid Dentures
Hospital Bed Catheter Ostomy
Feeding Tube
Other:

Notes about devices used:

PART X: Nutrition

Special Diet? If yes, explain:
Appetite: Good Fair
Poor
Allergies to any foods? If yes, list:
How many meals are consumed in a day? 1 3 Snacks
2
Chewing or swallowing problems?
Troublesome foods? If yes, explain:
Are there any special instructions for meal times?

PART XI: Cognitive/Behavioral Status

Is the applicant oriented to Person? Yes
No
Place? Yes No
Time? Yes No
Is the applicant's recent (short term) memory: Good Fair
Poor
Is the applicant's distant (long term) memory: Good Fair

Poor

What is your favorite family vacation memory?

Is the applicant able to understand verbal directions? Yes No

Is the applicant able to communicate needs (thirst, bathroom, hunger, etc.)? Yes No

If yes, how?

Is the applicant able to understand written directions? Yes No

Is the applicant aware of danger, risks, and consequences? Yes No

Any recent stressful events? If yes, describe:

What is the applicant's response to illness?

Circle any behaviors the applicant has experienced:

depressed anxious paranoid aggressive agitated withdrawn suicidal thoughts other:

Is the applicant receiving any mental health treatment? If yes, describe:

Is the applicant experiencing any current emotional problems or related behaviors such as wandering or sleeplessness? If yes, describe:

Part XII: Optional

Religious Affiliation:

Is there a need for additional services (available for a fee)? Shower Shave Podiatrist

What is one thing you wish people knew about you?

Any other notes or concerns:

Form completed by: _____
Name and Title

With:

_____
Name and Relationship

Applicant meets the criteria for admission: Yes No

If no, has applicant received written notice within 30 days of completion of intake screening?