



PAGE ROBBINS

ADULT DAY CENTER

1961 S. Houston Levee Road
Collierville, TN 38017
901-854-1200 (phone) 901-854-5726 (fax)

CLIENT APPLICATION TO BE SUBMITTED PRIOR TO ADMISSION INTERVIEW

Client Information

Name _____ Preferred Name to be called _____

Address _____

City / State / Zip Code _____ Phone _____

Birth date ____/____/____ Age _____ Height _____ Weight _____

Gender: Male Female Eye Color _____

Primary Language _____ Other Languages Spoken _____

Education: 8th grade High School College Other: _____

Previous Occupation(s) _____ Workplace _____

Age at retirement _____ Adjustment to retirement: Good Difficult

Veteran: No Yes Service _____ Eligible for VA benefits? Yes No

Branch _____ Rank _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name _____ If widowed, how did he/she adjust? _____

Responsible Party Information/Primary Caregiver

Name _____ Relationship to Client _____

Address _____

City / State / Zip Code _____ Home Phone _____

Work Place _____ Work Phone _____

Email address _____ Cell Phone _____

(Please circle or (*) your preferred contact phone number)

Does the primary caregiver live with the applicant? Yes No

If No, living arrangements:

Lives alone Spouse Relative Hired caregiver Other _____

Is the primary family caregiver employed?

Full time Part time Does not work outside the home Will work in the future

Does any other family member have/has any other family member had Alzheimer's disease?

Yes No

Has the applicant attended an Adult Day Care Program before?

Yes No

Preferred days for applicant to attend our center:

Monday Tuesday Wednesday Thursday Friday

How did you learn about our program? _____

Does the applicant have Long Term Care Insurance? Yes No

Medical Information and Hospital Preference

Doctor's Name _____ Specialty _____

Address _____ Phone Number _____

City, State _____ Hospital Preference _____

Last time hospitalized _____ Reason _____ Length of Stay _____

Will the applicant require assistance with medication while at the Center? Yes No

Is the applicant allergic to anything (medications, foods, latex gloves, insect stings, etc.)?

No Yes If Yes, what? _____

Has family completed a:

Durable Power of Attorney Advanced Directive
 POST Order (Do Not Resuscitate) Living Will

**If any of the above are marked, please provide a copy of the documents.

Does the family feel they understand the diagnosis of the applicant? Yes No

If No, what would you like to know? _____

Emergency Contacts and Persons Authorized to transport, sign in and sign out a client (other than primary caregiver). Please note: only a person who is 16 years or older may sign in or out a client. Please let us know if any of these phone numbers change. Note: We respect and protect the privacy of the information below.

Client Name:

Name/Address	Phone number	Email (For use only in emergency and/or periodic communication.)	Relationship to the applicant

Client Assessment Data

Diagnosis of memory impairment:

Memory impairment? Yes No

Date of diagnosis of dementia _____ Physician who made the diagnosis _____

Is the client aware of the diagnosis? Yes No

Specific Diagnosis _____

Briefly describe the onset of dementia and how the applicant and family responded to these changes:

Hearing Impairment:

Right Ear: No loss Some loss complete loss Hearing Aid Refuses to wear

Left Ear: No loss Some loss Complete loss Hearing Aid Refuses to wear

Visual Impairment:

Right Eye: No impairment Cataracts Implants Other:

Left Eye: No impairment Cataracts Implants Other:

Glasses: Yes No Does not wear, explain _____

Dentures: Yes No

Upper: Full Partial No teeth Removable bridge

Lower: Full Partial No teeth Removable bridge

Walking:

Steady on his/her feet: Yes No

Needs some help: Yes No Please explain _____

Assistive Equipment:

Cane Crutches Walker Wheelchair One to one assistance

Eating:

Without help Some help _____ Needs prompting to eat.

Please explain

Other considerations and food favorites or dislikes _____

Swallowing:

Does the applicant have problems swallowing his/her food? Yes No

Does the applicant store food in his/her mouth? Yes No

Does the applicant have problems with choking? Yes No

If yes, are there certain foods that cause choking? _____

Diet:

Regular No extra sugar No extra salt Other restrictions _____

Appetite:

Good Poor Eats too fast Other information _____

Favorite morning beverage? Coffee Hot tea Juice Water Other _____

Has there been any recent Weight loss Gain Neither Amount: _____lbs.

Does he/she smoke? Yes No (Please note that we are a smoke-free facility)

Toileting:

Incontinent of bladder: Yes No Nighttime only

Incontinent of bowel: Yes No Nighttime only

Products used in daytime: Nothing Liners Pads

Disposable underwear

Help required: None Reminders Physical Assistance
 Positioning Supervision Changing disposable garments

If a wheelchair and physical assistance are used, is the applicant able to stand and support his/her weight long enough to safely transfer to the toilet (abt 2 min.)? Yes No

Dressing:

Help required: None Lay out clothing Verbal cuing
 Physical assistance Other: _____

Bathing/showering:

Help required: None Verbal cuing Physical assistance

Level of Conversation/Language (Please circle yes or no):

Yes or No: Is able to converse in most social situations

Yes or No: Uses full sentences with descriptive details

Yes or No: Can communicate basic wants and needs

Yes or No: Understands directions for activities (to dress, eat, go outside, etc.)

Yes or No: Can recall most recent events and conversations

Yes or No: Can name family members they see regularly

Yes or No: Sentences do not make sense, may ramble

Yes or No: Often asks the same questions or tells the same stories over and over again

Behavior: please check all that apply

- Confusion about current events in their life, confusion about time and place
- Problems with judgment: making important decisions, can't handle major life decisions
- Difficulty concentrating on a task or activity
- Takes little or no interest in activities and will not start them by self
- Becomes anxious in noisy environments

- Hoards objects
- Wanders away from home: # of times _____ Wears a Medic Alert bracelet? Yes or No
- Cannot be left at home alone, must be supervised
- Requires constant attention and will not let you out of sight
- Becomes verbally aggressive When _____
- Becomes physically aggressive When _____
- Becomes anxious When _____
- Are there any words/subjects that upset him/her? Please explain _____

Engages in embarrassing and socially inappropriate behavior. What? _____

- Talks to people he/she does not know
- Denies or seems unaware that anything is wrong
- Reports seeing or hearing things that are not there
- Has episodes of paranoia Please explain _____
- Appears depressed
- Afraid of dogs
- Engages in behavior that is potentially dangerous to self or others; Please explain

Please list any other behaviors/habits or challenges that would be helpful for us to know.

Personality:

Before onset of illness _____ Current _____

Current patterns of relating to others: Outgoing Social Quiet Solitary

Does the applicant read? Yes No If Yes, what? _____

Does the applicant write? Yes No

Favorite things/Preferences and Life Experiences: (Please note; this information will help us to understand and share conversation with the applicant.)

Place of Birth _____

Places applicant lived as a child and as an adult:

If applicable, Cultural background _____

Memories/activities most often talked about:

Name and place of high school _____

If applicable, name of college _____ Major _____

If a veteran, where did the applicant serve and what did they do?

Brief work history: _____

Names of children and the most important people in the applicant's life:

Personal Interests:

Favorite vacations: _____

Faith-based activities and/or community service work: _____

Faith-based habits/rituals/beliefs that would be important for us to know: _____

Hobbies/Interests: _____

Art Experiences/Talent: _____

Music Experiences: Did/does the applicant play an instrument? Sing in a group? Play in a band?
Dance? Other? _____

What music did they and/or do they like to listen to? Favorite song(s)?

What genre of music did they like as a teenager or young adult? _____

Favorite reading materials, poems, stories, authors, magazines, etc.?

How did he/she spend their leisure time prior to the onset of dementia or frailty?

Which of these things can they still do? _____

How does the applicant currently spend their time during the day?

What is special about this applicant that you would like us to know?

Family Long Term Plan of Care:

Do you need information about:

- | | |
|--|--|
| <input type="checkbox"/> Long Term Care facilities | <input type="checkbox"/> Attorneys |
| <input type="checkbox"/> Respite Care | <input type="checkbox"/> Geriatric Case Managers |
| <input type="checkbox"/> In Home Care Services | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Physicians | <input type="checkbox"/> Other |

Would you be interested in information or attending any of our groups? Please check.

_____ General Caregivers Support Group on the 2nd Tuesday of every month. 4:00-5:00 pm

_____ Monthly Caregiver Information Workshop on the 3rd Thursday, 4:00-5:00 pm

Name of person completing this form _____

Date _____ Relationship to the applicant _____

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EMERGENCY TREATMENT FORM

Name _____ Date of Birth _____

Address _____

Gender _____ Marital Status _____ Age as of admit date _____

Responsible Party/Caregiver _____ Home Phone _____

Relationship to client _____ Work Phone _____

Home Address of Caregiver _____ Caregiver's Place of Work _____

_____ Cell Phone _____

2nd Name for Emergency _____ Home Phone _____

Address _____ Work Phone _____

_____ Cell Phone _____

Physician _____ Phone _____

Hospital Preference _____ Allergies _____

DNR (Do Not Resuscitate Order) or POST provided to the Center: () Yes Date provided _____ No ()

Diagnosis: _____

Responsible Party

Date completed

Witness

Date completed

Please initial below if in agreement.

___ The above signed have understood and agreed that Page Robbins Adult Day Center cannot be responsible for routine medical maintenance, care or consultation and that all arrangements for any medical problem or special physical or medical needs shall be the sole responsibility of the caregiver, guardian or responsible party.

___ The above responsible party provides permission to Page Robbins Adult Day Center to provide this Emergency Treatment Form, a DNR or POST (if available), and medical form to emergency personnel in case of an emergency.

Office Use Only:

Admit Date: _____

Discharge Date: _____