**Pine Heights Senior Adult Day Center**

**General Information**

Full Name:. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name You Prefer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suite/Apartment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_ May I Send Mail Here: □ Yes □ No

Home Phone: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I Leave a Message Here: □ Yes □ No

Cell Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I Leave a Message Here: □ Yes □ No

Work Phone: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I Leave a Message Here: □ Yes □ No

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I Send Email Here: □ Yes □ No

**RESPONSIBLE PARTY**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY EMERGENCY CONTACT**: (if other than Responsible Party)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER EMERGENCY CONTACTS:**

Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Pine Heights? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK ALL THAT APPLY:

[ ] Living Will [ ] Power of Attorney [ ] Durable Power of Attorney [ ] Conservator [ ] Guardian

**ADMISSION AGREEMENT**

I understand that my acceptance into Pine Heights SADC is provisional and that I

will be evaluated for two weeks by the staff of the Center for appropriateness of this

program for me.

Further, I understand that I might not be accepted into the Adult Day care program after

the provisional period for the following reasons:

1) I do not respond to the program.

2) I have some behavior(s) that interfere with the operation of the program.

3) I experience a physical or mental condition that indicates another level of

care.

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In addition, I understand that if I have any living habit or behavior that is disruptive to the

group that my continuance in the program will depend upon my correcting this problem.

I understand that Pine Heights SADC and my family will work with me to correct difficulties, and failing improvement, I will be discharged from the program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Participant or Guardian

**RIGHTS OF ADULT DAY CARE PARTICIPANTS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Each participant of Pine Heights SADC shall be assured of the following rights:

1. To be treated as an adult with respect and dignity regardless of race, color, or creed.

2. To participate in a program of services and activities which promote positive attitudes regarding one’s usefulness and abilities.

3. To participate in a program of services designed to encourage learning, growth, and awareness of constructive ways to develop personal interests and talents.

4. To maintain independence to the extent possible and to be involved in a program of services designed to promote personal independence.

5. To be encouraged to attain self-determination, including the opportunity to participate in developing one’s care plan for services, to decide whether or not to participate in any given

activity, and to be involved, to the extent possible, in program planning and operation.

6. To be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.

7. To have privacy and confidentiality.

8. To be free of mental and physical abuse.

9. To have access to a telephone to make or receive calls, unless the family indicates necessary restrictions.

10. To be free of interference, coercion, discrimination or reprisal.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Participant/Guardian

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Please tell us as much about yourself as possible in order for us to plan programs and activities that interest and benefit you.

**Places lived**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Places traveled**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation(s)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of Interest**:

\_\_ Games \_\_ Pets/Animals \_\_Television \_\_ Gardening \_\_ Music \_\_ Arts & Crafts

\_\_ Sports \_\_Woodworking \_\_ Handiwork \_\_ Movies \_\_ Exercise \_\_ Walking

\_\_ Reading \_\_ Museums \_\_ Shopping \_\_ Sewing \_\_ Cooking \_\_ Puzzles

Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clubs, Organizations and Volunteerism**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF RESPONSIBILITY**

**I would like to attend Pine Heights SADC and participate in the regularly scheduled activities. I acknowledge my participation in all activities sponsored by the Pine Heights SADC as voluntary and will not hold the Center nor any employees or volunteers responsible for any illness or accidents which may occur while I am a participant in the program. I understand that any financial liability incurred due to transport, treatment or extended care resulting from an accident or illness while in attendance at Pine Heights SADC is my sole responsibility. I further understand that if I wander away from or leave the facility without consent of the staff, I will not hold Pine Heights SADC or any employee or volunteer responsible for illness or accidents which may occur.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signature of Participant/Guardian**

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**ADDITIONAL SERVICES AGREEMENT**

**As a part of my attendance at Pine Heights SADC I hereby request the following additional services are provided me. I understand that I am fully responsible for the cost of such services and understand that I will be billed separately for these costs by the agency providing the service.**

**[ ] Physical, Speech, and/or Occupational Therapy Services**

**[ ] Mental Health Counseling Services**

**[ ] Home Health Services**

**[ ] No additional services requested**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signature of Participant/Guardian**

**PUBLICITY RELEASE**

**(Please check one)**

**[ ] I hereby consent to and authorize the use and reproduction by Pine Heights SADC, or**

**anyone authorized by the Center, for any and all photographs that you have taken of me for purposes connected with the publicity of Pine Heights SADC, without further compensation to me. The photographs and negatives shall constitute your sole property.**

**[ ] I DO NOT consent to NOR authorize the use and reproduction by Pine Heights SADC or anyone authorized by the Center, of any and all photographs that you have taken of me for purposes connected with the publicity of the Pine Heights SADC.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signature of Participant/Guardian**

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**Release of Participant’s Information**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, primary caregiver for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Pine Heights SADC to release information pertaining to this individual to the following people:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that **only** the above listed individuals will be given information pertaining to this participant. I understand that I am responsible for keeping this list up to date and do not hold Pine Heights SADC responsible if I fail to do so.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Caregiver Date*

**Leave Authorization**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, primary caregiver for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the Pine Heights SADC to allow the above mentioned individual to leave the Center with the following people:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will be allowed to leave the Center with **only** the above mentioned individuals. I understand that I am responsible for keeping this list up to date and do not hold Pine Heights SADC responsible if I fail to do so.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Caregiver Date*

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**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your patient, identified above, is interested in attending the Pine Heights SADC, a

organization striving to promote independent functioning and social needs of

older and handicapped citizens. A weekday program of services includes occupational

and recreational activities, regular nurse evaluations, social services, physical therapy

consultations, as indicated, planned activities, meals, morning and afternoon snacks, and

transportation to and from the Center, if needed.

By state law, you must be advised that:

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS

WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR

VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO

DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND HUMAN

IMMUNO-DEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE

DEFICIENCY SYNDROME (“AIDS”).

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give consent to

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (personal physician) and to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hospital/facility) to release health

information to Pine Heights SADC, so the Center might be informed in order to

assist with my health care. I understand this consent can be revoked at any time except to

the extent that disclosure made in good faith has already occurred in reliance on this

consent. All employees, officers, attending physicians, and physicians listed above are

released from legal responsibility for the release of the requested information.

Dated this \_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Signature of Participant/Guardian

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**Consent to Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations**

Name of Patient/Individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the Center maintain, use, and disclose personal health information in order to

provide for my care and treatment, to arrange for billing and payment for my care and carry out

general management and operations of the facility such as quality review.

I understand that these and other uses and disclosures of my personal health information are

described more completely in the facility’s Notice of Privacy Practices.

I understand that the Center reserves the right to change its privacy practices described in the

Notice of Privacy Practices and to make the new Notice provisions effective for all protected

health information already received and maintained by the Center as well as for new information.

I understand that prior to implementation; the Center will mail a copy of the revised Notice of

Privacy Practices to the address I have provided. In addition, I understand that I have the

following rights:

The right to receive and review the facility’s Notice of Privacy Practices before signing

this Consent.

The right to request restrictions on how protected health information about me is used or

disclosed for treatment, payment, or health care operations. The facility is not required to

agree to my request, but if it does, it will be bound by its agreement.

The right to revoke this Consent, in writing, except to the extent the facility has acted in

reliance on the Consent.

The right to receive a copy of this Consent form.

I consent to the use and disclosure by Pine Heights SADC and its agents or representatives

of all my personal health information for purposes of treatment, payment and health care

operations.

By signing below, I acknowledge that I have read and understand this Consent form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant/Authorized Representative/ Date

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**PARTICIPANT MEDICAL HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of all Diagnoses: (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(5)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of all Medications and Allergies:

MEDICATIONS ALLERGIES

(1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(5)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(7)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (8) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgeries and Dates:

(1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(4)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of TB or Positive TB Skin Tests? [ ] Yes [ ] No

At Risk for HIV Infection? [ ] Yes [ ] No

Weight Loss or Gain in the last 6 months? [ ] Yes [ ] No

Is there a DNR (Do Not Resuscitate) Order? [ ] Yes [ ] No

**Have you ever experienced any of the following health problems? (Check all that apply)**

[ ] Diabetes [ ] Depression [ ] Heart Disease [ ] Heart attack

[ ] Heart Failure [ ] Alzheimer’s disease [ ] Stroke [ ] Inability to Speak

[ ] Chronic Lung Disease [ ] High Blood Pressure [ ] Pneumonia [ ] Memory Problems

[ ] Stomach Problems [ ] Paralysis [ ] Bowel Problems [ ] Joint Pain/Arthritis

[ ] Parkinson’s disease [ ] Urinary Infections [ ] Diarrhea [ ] Pacemaker

[ ] Dizziness [ ] Osteoporosis [ ] Incontinence [ ] Fractures

[ ] Multiple Sclerosis [ ] Seizures [ ] Skin Problems [ ] Anemia

[ ] Headaches [ ] Constipation [ ] Head Injuries [ ] Thyroid Problems

[ ] Kidney Problems [ ] Cancer – please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Hernias – please specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] History of Alcoholism [ ] History of Combativeness

[ ] Other Behavioral Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other Case Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Pine Heights SADC

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**SAFETY ASSESSMENT WORKSHEET**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Are you having difficulty buttoning buttons or snaps on clothing? [ ]YES [ ]NO**

2. Do you require assistance when getting dressed? **[ ]YES [ ]NO**

3. Have you noticed a decrease in your arm strength? **[ ]YES [ ]NO**

4. Are you having difficulty lifting or raising your arms over your head? **[ ]YES [ ]NO**

5. Are you having difficulty holding kitchen utensils or feeding yourself? **[ ]YES [ ]NO**

6. Are you having difficulty maintaining your balance while standing, washing

or putting dishes away or brushing your teeth at the sink? **[ ]YES [ ]NO**

7. Have you recently experienced a decrease in strength, endurance/stamina or

mobility? **[ ]YES [ ]NO**

8. Are you having difficulty speaking and communicating your needs? **[ ]YES [ ]NO**

9. Is it difficult to sit on the edge of your bed without falling toward one side

or another? **[ ]YES [ ]NO**

10. Are you having difficulty getting in and out of your bathtub? **[ ]YES [ ]NO**

11. Do you have difficulty getting in and out of bed? **[ ]YES [ ]NO**

12. Are you having difficulty walking or have you had falls recently? **[ ]YES [ ]NO**

13. When walking, do you require assistance from a walker, cane, etc.? **[ ]YES [ ]NO**

14. If currently using an assistive device, do you have difficulty getting in and

out of a chair? **[ ]YES [ ]NO**

15. Do you have difficulty using your assistive device? **[ ]YES [ ]NO**

16. If you use a wheel chair, do you have difficulty transferring to or from your

bed, recliner, toilet, etc? **[ ]YES [ ]NO**

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**Physician’s Orders**

***Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***DOB: \_\_\_\_\_\_\_\_\_\_\_\_***

***Date of last physical assessment: \_\_\_\_\_\_\_\_\_\_\_***

***List of all diagnoses: 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Weight & vital signs (once every month unless otherwise stated) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Test blood sugar, according to orders, only diabetics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Other treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Is there a DNR order?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Medications: (Please include dosage, times, and OTC meds)***

***1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies***

***3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***7) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Dietary needs: (please check one)***

***[ ] General or regular diet [ ] General diabetic diet***

***[ ] Sodium restricted [ ] other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***My patient may have any of the following on a prn basis. Please check:***

***Tylenol (500 mg) \_\_ cough syrup \_\_ antacids \_\_ other***

***My client may receive wound care of H2O and soap for scrapes and cuts [ ] YES [ ] NO***

***May participate in group “chair exercises”? [ ] YES [ ] NO***

***May participate in chair pedaling? [ ] YES [ ] NO***

***May use recumbent leg/arm exercise machine? [ ] YES [ ] NO***

***Activity level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone: \_\_\_\_\_\_\_\_\_ fax: \_\_\_\_\_\_\_\_\_\_\_***

***Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Date Signature of physician***

**DUE TO FAX PRINTING PLEASE COMPLETE ENTIRE FORM AS LEGIBLY AS POSSIBLE.**