



ADULT DAY HEALTH CARE

Norfolk Adult Day Health Center & Mansfield Adult Day Health Center  
**APPLICATION FOR SERVICES**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
(First) (Middle) (Last) (Maiden) (Nickname)

Address: \_\_\_\_\_ Resides with: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: M S W D Social Security #: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Medex #: \_\_\_\_\_ Mass Health #: \_\_\_\_\_

Person Responsible for Client Finances: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Fax # \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Fax # \_\_\_\_\_

**Medical History** Allergies: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnoses: \_\_\_\_\_

Admissions (Indicate Reason): Mental Health Facility: \_\_\_\_\_

Medical Hospital: \_\_\_\_\_

Nursing Home or Rehab: \_\_\_\_\_

Hospital Preference, in Emergency: \_\_\_\_\_

Recent Work-ups: \_\_\_\_\_

**In-Home Services Currently Receiving ( please list agency providing service and frequency of services):**

Nurse \_\_\_\_\_ Home Health Aide \_\_\_\_\_

PT \_\_\_\_\_ OT \_\_\_\_\_ Speech \_\_\_\_\_ Social Services \_\_\_\_\_

Homemaker \_\_\_\_\_ Meals on Wheels \_\_\_\_\_

Case Manger \_\_\_\_\_ Volunteers \_\_\_\_\_

Friendly Visitor \_\_\_\_\_ Other \_\_\_\_\_

Please List ALL medications, dosages, frequency, and route: \_\_\_\_\_

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

Who provides assistance with medications? \_\_\_\_\_

Which pharmacy is used? \_\_\_\_\_

Mobility ( Please Circle): Cane / Walker / Wheelchair / Physical Assist to Transfer

Dressing: Independent: \_\_\_\_\_ Minimal Assist: \_\_\_\_\_ Total Assist: \_\_\_\_\_

Bathing: Independent: \_\_\_\_\_ Minimal Assist: \_\_\_\_\_ Total Assist: \_\_\_\_\_

Toileting: Independent: \_\_\_\_\_ Minimal Assist: \_\_\_\_\_ Total Assist: \_\_\_\_\_

Incontinent: Bowel: \_\_\_\_\_ Bladder: \_\_\_\_\_ Wears Disposable Undergarments: \_\_\_\_\_

Eating: Independent: \_\_\_\_\_ Minimal Assist: \_\_\_\_\_ Total Assist: \_\_\_\_\_

**Family History:**

Name of Spouse: \_\_\_\_\_ Years Married: \_\_\_\_\_

Years Widowed (if applicable): \_\_\_\_\_ Cause of Death: \_\_\_\_\_

# of Children: Sons \_\_\_\_\_ Daughters \_\_\_\_\_ Deceased \_\_\_\_\_

# of Siblings: Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Deceased \_\_\_\_\_

Impact of client's illness on family: \_\_\_\_\_

\_\_\_\_\_

**Social History**

Birth Place: \_\_\_\_\_ Language/National Heritage: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Retirement: \_\_\_\_\_ Religion: \_\_\_\_\_

Activity Since Retirement: \_\_\_\_\_

Please Indicate Past and Present Interest in the Following:

Crafts: \_\_\_\_\_

Games: \_\_\_\_\_

Cards: \_\_\_\_\_

Outings: \_\_\_\_\_

Discussion: \_\_\_\_\_

Exercise: \_\_\_\_\_

Intellectual Stimulation: \_\_\_\_\_

Reading: \_\_\_\_\_

Music: \_\_\_\_\_

Spirituality: \_\_\_\_\_

Cultural or Ethnic Activities: \_\_\_\_\_

**Social Behaviors** (please check those that apply; you may add comments below)

Talk with others: \_\_\_\_\_ Visit with others: \_\_\_\_\_

Helps others: \_\_\_\_\_ Smiles, Laughs: \_\_\_\_\_

Anxious: \_\_\_\_\_ Irritable: \_\_\_\_\_  
Agitated: \_\_\_\_\_ Lethargic, withdrawn: \_\_\_\_\_  
Wanders: \_\_\_\_\_ Cooperative: \_\_\_\_\_  
Forgetful: \_\_\_\_\_ Follows Directions: \_\_\_\_\_  
Physically abusive: \_\_\_\_\_ Verbally abusive: \_\_\_\_\_

Past History or Current Substance Abuse: \_\_\_\_\_

What are your reasons for using Adult Day Health? (Check all that apply)

Socialization/Friendships: \_\_\_\_\_ Intellectual/Cognitive Stimulation: \_\_\_\_\_  
Safety: \_\_\_\_\_ Caregiver Respite: \_\_\_\_\_  
Mental Health Counseling: \_\_\_\_\_ Rehab: PT \_\_\_\_\_ OT \_\_\_\_\_ Speech: \_\_\_\_\_  
Medication management: \_\_\_\_\_ Nursing Services/Supervision: \_\_\_\_\_  
Social Services/Case Management: \_\_\_\_\_ Therapeutic Recreation: \_\_\_\_\_

Any other information you would like us to know: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Who assisted client in filling out form: \_\_\_\_\_  
Circle: spouse / son / daughter / responsible party / Legal guardian

Please mail or fax this form to the appropriate location:

**Norfolk Adult Day Health Center**  
595 Pleasant Street  
Norwood, MA 02062  
Tel 781-769-4495  
Fax 781-769-9005

or

**Mansfield Adult Day Health Center**  
300 Branch Street  
Mansfield, MA 02048  
Tel 508-339-2119  
Fax 508-339-3820