



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