

## Fresh Start Adult Day Program Application

Date of Intake: \_\_\_\_\_ Name of Referral: \_\_\_\_\_

### Participant Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

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

City: \_\_\_\_\_ County: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ SSN: \_\_\_\_\_

Veteran: Yes \_\_\_\_\_ No \_\_\_\_\_ Primary Disability: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

### Primary Caregiver Information:

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

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

City: \_\_\_\_\_

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

Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Medical Assistance: (PMI): \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

County: \_\_\_\_\_

Public Health Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

### Funding Source:

Private Pay     Elderly Waiver     Alternate Care     Other

CADI Waiver     OBRA     TBI Waiver     POS

Bill to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary Language: \_\_\_\_\_ Ethnic Background: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Current Living Arrangements: \_\_\_\_\_

Religion: \_\_\_\_\_

Conservator: \_\_\_\_\_ Guardian: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

What does the guardian have authority over?

Personal needs \_\_\_\_\_ Estate \_\_\_\_\_ Both \_\_\_\_\_

**Emergency Contact:**

First Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: (h) \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (w) \_\_\_\_\_

Second Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: (h) \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (w) \_\_\_\_\_

**Medical Information:**

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

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

Secondary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Date of last physical examination: \_\_\_\_\_

Reason for doctor's visit: \_\_\_\_\_

Mayo Clinic Number: \_\_\_\_\_ OMC Number: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last chest x-ray: \_\_\_\_\_

Do you have a living will: Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please bring a copy for your file

Do you have an order for DNR (Do not resuscitate) Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please bring a copy for your file

If you do not have a DNR, do you give us permission to perform CPR in the event of an emergency Yes \_\_\_\_\_ No \_\_\_\_\_ Initial \_\_\_\_\_

Health Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_

\*Please note any changes in medications or dosages need to be reported immediately to Program Director or Program RN\*

Medication Allergies: \_\_\_\_\_

Ambulation: \_\_\_\_\_

Hearing: Good \_\_\_\_\_ Poor \_\_\_\_\_ Wears hearing aids \_\_\_\_\_

Description of impairments: \_\_\_\_\_

Vision: Good \_\_\_\_\_ Poor \_\_\_\_\_ Wears glasses \_\_\_\_\_

Description of impairments: \_\_\_\_\_

**Dietary Information:**

Dietary Needs: Regular \_\_\_\_\_ Special \_\_\_\_\_

Specific Requirements: \_\_\_\_\_

Preparation: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

**Toileting:**

Is continent \_\_\_\_\_ Is continent but wears protective garments \_\_\_\_\_

Requires some assistance in the restroom \_\_\_\_\_

Do you smoke: Yes \_\_\_\_\_ No \_\_\_\_\_

Fresh Start Adult Day Program can provide transportation to and from our program within Rochester city limits. However we do not have a lift in our van for wheelchairs.

Will you be using our van service: Yes \_\_\_\_\_ No \_\_\_\_\_

Fresh Start Adult Day Program is open Monday- Friday from 8:30am to 4:00pm

**Scheduled days of attendance:**

Monday  Tuesday  Wednesday  Thursday  Friday

All information on this application is true and valid. Fresh Start Adult Day Program is free to use this information to better serve my needs. It is my responsibility to let the staff know of any changes that would affect my health and well being. This information can be shared with the Fresh Start Adult Day Program staff to further my care.

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

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

Guardian: \_\_\_\_\_

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

Please send completed for to:

Fresh Start Adult Day Program

1500 1<sup>st</sup> Ave NE

Suite B

Rochester, MN 55906

Or Fax: 507-282-1345

Program Director: \_\_\_\_\_

Date Received: \_\_\_\_\_

Date of Admission: \_\_\_\_\_