445 A Willard Ave
Newington, CT 06111

ADMISSION ASSESSMENT FORM

Date_____ Admission Date_____

Name: _____ Home# ( ) _____Cell # ( )_____

Address: _____ Apt # _____

Town: _____ State _____ Zip _____

SS#_____-_____-_____ Medicare#_____ Title 19#_____

Long Term Insurance Company-Policy #_____

HOME CARE FOR ELDERS PROGRAM YES NO EDUCATION_____

DOB_____/_____/_____BIRTHPLACE: TOWN_____STATE_____

MARITAL STATUS: S D M W OCCUPATION:_____RELIGION_____

VETERAN: YES NO VA BENEFITS YES NO EDUCATION:_____

LIVING ARRANGEMENTS: ALONE SPOUCE OTHER_____

NUMBER OF CHILDREN:_____HOUSING_____

DAYS ATTENDING: M T W TH F SAT = _____DAYS

TRANSPORTATION: FAMILY ADULT DAY CARE AM PM / FAMILY AM PM

ASSIST REQUIRED DURING TRANSPORTING:_____

PRIMARY PHYSICIAN:_____TELEPHONE#:___(_____)_____ - _____

ADDRESS:_____HOSPITAL_____

OTHER PHYSICIANS_____

ALLERGIES: _____

MEDICAL HISTORY: _____

DO NOT RESUSCITATE BRACELET YES NO LIVING WILL YES NO (IF YES, please provide copy)

DIET DIABETIC --- INSULIN DEPENDENT NO SALT, NO SWEETS, SOFT, MODIFIED SOFT, CUT UP

VISION:_____HEARING_____HEARING AIDE R L

SPEECH: CLEAR, SLURRED, APHASIC, OTHER _____

COGNITION: UNDERSTANDS, NEEDS CUEING, POOR JUDGMENT

MEMORY: SHORT TERM GOOD_____FAIR_____POOR

LONG TERM GOOD_____FAIR_____POOR

EMOTIONAL STATUS:_____

BEHAVIORAL STATUS;_____

MOBILITY:_____ASSISTIVE DEVICES_____

SPECIAL ACCOMMODATIONS:_____

GROOMING & PERSONAL CARE: INDEPENDENT WITH ASSIST

SHOWERING SERVICES AT FAMILY ADULT DAY CARE: YES NO

TOILETING: INDEPENDENT _____ASSIST_____INCONTINENCE BOWEL AND/OR BLADDER

I GIVE OR REFUSE PERMISSION FOR FAMILY ADULT DAY CARE TO TAKE PHOTOS AND OR VIDEOS FOR PUBLICITY PURPOSES.

I UNDERSTAND THAT FAMILY ADULT DAY CARE IS NOT RESPONSIBLE FOR LOST OR STOLEN ITEMS BROUGHT TO THE CENTER(VALUABLES, MONEY, JEWELRY, CLOTHING.)

I UNDERSTAND THAT I AM RESPONSIBLE FOR REPORTING ANY CHANGES OF CONDITION, MEDICATIONS, INJURIES, DAYS OF SERVICE AND ABSENCES TO FAMILY ADULT DAY CARE STAFF.

I HAVE RECEIVED A COPY OF THE POLICY OF HIPAA.

SIGNATURE_____DATE:_____