

PRACTITIONER ORDERS REQUIRED BEFORE 1ST ATTENDANCE DAY:

Med. Admin. BSL Monitoring DNR/EMS Status Other Nursing _____

Date(sent): _____ Date Returned: _____

Date: _____ Staff: _____

Referral Source: _____ Telephone Number: _____ ADC ADH Nursing OT

GENERAL INFORMATION

Name: _____ DOB: _____ Age: _____

Address: _____ Zip: _____

Phone: _____ Living Situation: _____ AFH has RN/LPN: Yes No

Alternative Decision Makers: Guardian: _____ DPOA _____ POA _____

Family/Caregiver Contact Name: _____ Phone: _____ Work: _____

Address: _____ Zip: _____ Relationship: _____

Emergency Contact Name: _____ Phone: _____ Work: _____

Address: _____ Zip: _____ Relationship: _____

MEDICAL INFORMATION

Hospital of choice: _____

Primary Physician: _____ Fax Number: _____

Address: _____ Phone: _____

Advance Directive in Place: Living Will: _____ DNR Order Req. _____ EMS/DNR _____

MEDICAL HISTORY: (Check all that apply and date diagnosed)

Endocrine

Diabetes: _____ Controlled by: _____

Cardio Pulmonary

HTM _____ CHF: _____

Oxygen: _____ flow: _____

MI: _____ COPD: _____

Other: _____

Cerebral Vascular / Neuro

CVA: _____ Area affected: _____

Head Injury: _____ Seizures: _____

Cerebral Palsy: _____ MS: _____

Other: _____

Sensory

Visually Impaired: Yes No

Glaucoma: _____ Cataracts: _____

Blind: _____ HOH: _____ AIDS _____

Urinary (G.U.)

Cath: _____ Dialysis: _____

Other: _____

Orthopedic

Arthritis: _____

Joints Affected: _____

Hx Falls/Fractures: _____

Other: _____

Gastro/Intestinal (G.I.)

Ulcer: _____ Cholestomy: _____

Recent Surgery: _____

Cognitive Disorder

Dementia: _____

Alzheimers: _____ Years Diagnosed: _____

Mental Health

Depression: _____ Schiz: _____ Manic Dep: _____

Other: _____

Developmental Disability

Type: _____ Mild: _____ Mod: _____ Profound: _____

Other: _____

Medication (See attached list in Admission Packet)

Independant: _____ Needs Assistance: _____

Will need to take at ADH: Yes No

Med Allergies: _____

Diet

Regular: _____ Diabetic: _____ Modified: _____

Tube: _____ Thick Liquids: _____

Hx Choking: _____ Swallow eval: _____

Fluid Restrictions: _____

Food Allergies: _____

ADLS AND ASSISTANCE NEEDED:

	Independent	Minimal	Assist Moderate	Assist Dependant
Toileting:	_____	_____	_____	_____
Eating:	_____	_____	_____	_____
Hygiene/Grooming:	_____	_____	_____	_____
Ambulation/Mobility:	_____	_____	_____	_____
Transfers:	_____	_____	_____	_____

List any equipment used or needed: Cane walker Wheel Chair Other: _____

Incontinent? Yes No Explain/Supplies used: _____

Is there a history of wandering, combativeness, anxiety, restlessness, impaired judgment? Yes No

Explain: _____

Activities/strategies to engage/soothe: _____

Communication Needs? Yes No Explain: _____

PREVIOUS THERAPIES

Date

Provider Name

Physical: _____

Occupational: _____

Speech: _____

Other Community Services: _____

FINANCIAL

Social Security Number: _____

Medicare Number: _____

SSI: Yes No

Medical Insurance: Secure Horizons Group Health

Other: _____

Medicaid coupons:(CNP) Yes No

Pic #: _____

Community Case Manager: _____

Telephone #: _____ Fax# _____

of Days/Wk Services Authorized: _____

Monthly Income: _____ 1 2 person

Liquid Assets single < 10,000 Yes No

Liquid Assets married < 15,000 Yes No

Send bills to: _____

Funding source will be: _____

Date/Notes: _____

TRANSPORTATION

Transportation: Para Shuttle Private

Registered with Pierce Shuttle: Yes No

Needs Application: Yes No

Send to: _____

Transports with: w/c electric cart walker cane none

Can be dropped off alone: Yes No

Pick-up and drop off address is the same: Yes No

Preferred days: _____

Days Scheduled: M T W Th F

<p>ANNUAL RE-ASSESSMENT DATE:</p> <p>_____</p>
