



Keystone

Adult Day Program

1350 Oak Ridge Turnpike
Oak Ridge, TN 37830
(865) 483-6631

Applicant General Information

Name _____ Preferred Name to Be Called: _____

Address _____

City/State/Zip Code: _____ Phone: _____

Applicant Personal Information-This information will remain confidential.

Social Security Number: XXX-XX-____ Medicare Number: XXX-XX-____ BirthDate: ____/____/____

Height _____ Weight _____ Sex: Male Female

Applicant Preferences (Please Check)

Preferred Days: Monday Tuesday Wednesday Thursday Friday

Primary Caregiver or Responsible Person Information

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/ Zip Code: _____ Home Phone: _____

Work Place: _____ Work Hours: _____

Work Phone: _____ Pager Number: _____

Mobile Phone: _____ Other Phone: _____

E-mail: _____

Is the billing address the same? Yes No (If no, please provide correct information below.)

Billing Name _____

Billing Address: _____ City/ State/ Zip Code: _____

How did you find out about Keystone Adult Day Program? _____

Advance Directives

Power of Attorney Living Will Do Not Resuscitate None Other

Power of Attorney's Name: _____

For office use only

Please furnish Keystone Adult Day Program with a copy of any that may apply.

Emergency Contacts and Persons Authorized to Transport Applicant (other than primary caregiver listed on page 1)

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/ Zip Code: _____ Home Phone: _____

Work Place: _____ Work Hours: _____

Work Phone: _____ Pager Number: _____

Mobile Phone: _____ Other Phone: _____

E-mail: _____

For office use only

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/ Zip Code: _____ Home Phone: _____

Work Place: _____ Work Hours: _____

Work Phone: _____ Pager Number: _____

Mobile Phone: _____ Other Phone: _____

E-mail: _____

For office use only

Applicant _____ **Caregiver** _____

Primary Physicians – Hospital Preference

Doctor's Name: _____ Doctor's Name: _____

Specialty: _____ Specilaty: _____

Address: _____ Address: _____

City/State/Zip Code: _____ City/State/Zip Code: _____

Phone: _____ Phone: _____

Hospital Preference: _____ **Last Time Hospitalized:** _____

Reason: _____ **Length of Stay:** _____

Long-term effects: _____

Safe Return Information

Is the Applicant registered in this national program for possible wanderers? Yes No

If you answer yes, please record registration number here: _____.

Applicant Assessment

If you answer yes, please explain.

Has there been any recent Weight loss? Gain? No Amount: _____ lbs. How Long: _____

Are there any Drug Allergies: Yes No What Drugs: _____ Type of Reaction: _____

Are there any Food Allergies: Yes No What Foods _____ Type of Reaction: _____

Does He/She Smoke/Chew/Dip: Yes No How Much?: _____

Can the Applicant Read? Yes No

Does the Applicant Write? Yes No

Is the Applicant: Left Handed? Right Handed?

Hearing Impairment:

Right Ear: No Hearing Loss Some Hearing Loss Complete Hearing Loss Hearing Aid Refuses to Wear Aid

Left Ear: No Hearing Loss Some Hearing Loss Complete Hearing Loss Hearing Aid Refuses to Wear Aid

Visual Impairment:

Left Eye: No Impairment Cataracts Implants Other: _____

Right Eye: No Impairment Cataracts Implants Other: _____

Glasses: Reading Distance Bifocals Does not wear, explain: _____

Applicant _____ **Caregiver** _____

Dentures: Yes No

Upper: Full Partial No Teeth Removable bridge No Teeth

Lower: Full Partial No Teeth Removable bridge No Teeth

Describe how well you think the applicant functions in the following areas.

Walking:

Steady on his/her feet Yes No

Without any help Yes No

With some help Yes No Explain: _____

Cane Crutches Walker Supervised walking One to one assistance

Eating:

Without Help Some Help _____ Needs to be prompted to eat

Please explain

Other consideration: _____

Swallowing:

Does the applicant have problems swallowing his/her food? Yes No

Does the applicant store food in his/her mouth? Yes No

Diet:

Regular No Extra Sugar No Extra Salt Other Restrictions: _____

Appetite:

Good Poor Eats too fast

Please list any food dislikes:

Toileting

Bowel and Bladder:

Incontinence of Bladder: Yes No Nighttime Only

Incontinence of Bowel: Yes No Nighttime Only

Products Used in Daytime: Nothing Panty Liners Pads Adult Diapers Other: _____

Help Required: None Reminders Physical Assistance Supervision Hygiene Diapers

Any other toileting concerns? If so, please explain.

Dressing

- Help Required: None Lay out clothing Supervise only Verbal cuing Physical Assistance Cooperative
 Resistant

Behavior (Please check ALL that apply)

Communication

- Difficulty communicating wants and needs
- Difficulty completing sentences
- Sentences do not make sense
- Difficulty naming people
- Difficulty expressing self Please explain: _____
- Has difficulty concentrating on a task or activity
- Takes little or no interest in activities and will not start them by self
- Often asks the same questions over and over again
- Loses or misplaces objects
- Has difficulty following simple directions
- Hoards objects
- Wanders away from home: # of times: _____ Wanderer's Bracelet Medic Alert Bracelet
- Cannot be left alone, must be supervised
- Demands constant attention and will not let you out of sight
- Becomes verbally abusive When: _____
- Becomes combative When: _____
- Becomes anxious When: _____
- Becomes agitated When: _____
- Becomes stubborn or uncooperative When: _____
- Engages in embarrassing or socially inappropriate behavior How: _____
- Talks to people he/she doesn't know
- Denies or seems unaware that anything is wrong
- Reports seeing or hearing things that are not there
- Frequently appears depressed or withdrawn
- Engages in behavior that is potentially dangerous to self or others What: _____

Please list any other behavior that you may be aware of:

Personality

Before onset of illness _____ Current _____

- Pattern of relating to others Outgoing Involved Social Loner

Applicant _____ **Caregiver** _____

Applicant Assessment (cont)

Primary Caregiver Spouse Child Other _____

Who would you say is the primary person responsible for Applicant? _____

Does primary caregiver live with Applicant? Yes No

If no, living arrangements: Lives Alone Spouse Relative Hired Caregiver Other

Is primary caregiver employed? Full time Part time Does not work Will work in future

Does the primary caregiver attend a support group? Yes No

Family Goals for daycare Socialization Stimulation Family Relief Supervision Other _____

Names that the Applicant most remembers: Name: _____ Relationship to Participant _____

Name: _____ Relationship to Participant _____

Applicant Interests (Current and past)

Previous Occupation: _____ Work Place: _____

	Current		Past			Current		Past		
Listening to Music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Singing	<input type="checkbox"/>	<input type="checkbox"/>	Playing Instrument	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Games	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>
Knitting/Sewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	Cooking/Baking	<input type="checkbox"/>	<input type="checkbox"/>
Gardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dancing	<input type="checkbox"/>	<input type="checkbox"/>	Looking at Magazines	<input type="checkbox"/>	<input type="checkbox"/>
Handyman, Mr.Fixit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pets/animals	<input type="checkbox"/>	<input type="checkbox"/>	Traveling	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drawing & Painting	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

How does the applicant currently spend his/her day?

Name of person completing this form: (Please Print): _____

General Applicant Data-OPTIONAL-For Statistical Purposes Only

Gender: Male Female Place of Birth: _____ Ethnic Background _____
City/State

Primary Language Spoken: English Other: _____

Nickname: _____ Likes to Be Called: _____ Religion: _____

Applicant _____ **Caregiver** _____

Is the applicant a veteran: Yes No

Education: 8th grade High School College Other: _____

Marital Status: Single Married Divorced Separated Widowed If widowed, how did he/she adjust? _____

What have we not asked you that you think we need to know?



Fax return to: (865) 483-9011

Medical Examination

Date: _____

TO: _____

MD Fax: _____

Your Patient's(Name): _____

(Address): _____

is making application to attend the Keystone Adult Day Program. Please complete the following and return to Keystone Adult Day Program at 1350 Oak Ridge Turnpike, Oak Ridge, TN 37830 (865) 483-6631.

Your patient cannot be enrolled until this form is returned to us:

Primary Diagnosis: _____

Secondary Diagnosis: _____
(Use back if necessary)

Date of last examination: _____

I certify that _____ is free from any communicable diseases and is also able to participate in an adult day program with the following limitations:

Physical limitations: _____

Dietary limitations: _____

Allergies: _____

Physician's Name: _____

Address: _____

Phone: _____

Date: _____ Signature: _____

MEDICAL RECORD RELEASE		
To: _____	<small>(Doctor, Hospital, or Health Department)</small>	
Address: _____	<small>Address</small>	<small>City/State</small>
		<small>Zip Code</small>
I hereby authorize and request you to release to:		
Keystone Adult Day Program 1350 Oak Ridge Turnpike Oak Ridge, TN 37830		
Name: _____	<small>(Patient)</small>	
Address: _____	<small>Address</small>	<small>City/State</small>
		<small>Zip Code</small>
Medical Records and /or other information concerning my illness and/or treatment of _____		
Sign Here: _____	Date: _____	
<small>(Participant of Responsible Party)</small>		



FINANCIAL RESPONSIBILITY (REQUIRED)

I, (please print) _____ understand that I am responsible for all
Caregiver/Responsible Party
fees and charges incurred by (please print) _____ at Keystone Adult Day Program.
Participant

Sign Here: #1 Signature Date

Billing Address if different than caregiver’s address:

City/State/Zip

AUTHORIZATION FOR EMERGENCY CARE (REQUIRED)

I understand that Keystone is a social agency and that no medical services are available at Keystone. I hereby authorize Keystone to have the above named participant transported by ambulance for medical treatment in the event of an emergency. I agree to pay for all costs incurred. I also give permission for Keystone’s staff to provide emergency medical personnel with any information which will assist them in the treatment of the emergency.

Sign Here: #2 Signature Date
_____ Caregiver/Responsible Party

NOTICE AND AGREEMENT (REQUIRED)

The caregiver shall hold Keystone harmless against all losses, damages, accidents or injuries to person or property of any participant of family member, guest, or invitee of the participant or caregiver caused by or resulting from or in connection with his/her/their use or occupancy of the Keystone premises.

Sign Here: #3 Signature Date
_____ Caregiver/Responsible Party

PHOTO/MEDIA/ARTWORK/RELEASE (OPTIONAL)

I give to Keystone unlimited permission to use, publish, and republish in the furtherance of it’s work, reproductions of my likeness by photographic or electronic media means (such as television, Internet) for non-commercial and fundraising purposes, with the use of my first name. I give my permission for my voice to be recorded and my art work, or a reproduction to be used without compensation to me or to my family.

Please note: Failure to agree to Photo/Media/Artwork release will not affect you family member’s eligibility for the program.

Sign Here: Signature Date
_____ Participant

And/Or: #4 Signature Date
_____ Caregiver/Responsible Party

