WTMM ADULT DAY HEALTH CARE CENTER
PARTICIPANT APPLICATION

10192 Halls Ferry Road, St. Louis, MO 63136 ▪ Phone: (314) 867-0048 ▪ Fax: (314) 388-4849

Name (Last)	First	M.I.
DOB	Marital Status	Sex: Male Female
Address		Apt/Unit
City	State	ZIP
Phone(Home)	Phone (Cell)	
Social Security No.	Medicare No.	Medicaid No.
Other Insurance	Identification No.	
Religion		

Please list all members of participant's household (include yourself):

Name	Relationship	Age	Employer	Work No.	Cell No.

Other close relatives:

Name	Relationship	Age	Phone/Cell No.

Emergency Contact Information:

Name	Relationship	Phone No.	Alternate or Cell No.

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Persons authorized to pick up participant (if different from above)

Name	**Relationship**	**Cell**
Address		**Phone**
Name	**Relationship**	**Cell**
Address		**Phone**
Name	**Relationship**	**Cell**
Address		**Phone**

1. **Please check any of the following which may apply to the participant:**

Vision problems (reading newspaper, watching TV, etc.) _____ **Deafness** _____
Hearing problems (in a group, on the phone, etc.) _____ **Balance problems or dizziness** _____
Blindness _____ **Walking problems** _____

2. **Check any of the following that the participant requires:**

Glasses/Contacts _____ **Wheel Chair** _____
Hearing aids _____ **Dentures** _____
Walking Cane/Walker _____ **Colostomy/Ileostomy aid** _____
Other(s) _____

3. **Does the participant have any problems or need assistance with:**

	major	minor	none		major	minor	none
Bathing	☐	☐	☐	**Thinking**	☐	☐	☐
Dressing	☐	☐	☐	**Conversations**	☐	☐	☐
Facial care	☐	☐	☐	**Wandering**	☐	☐	☐
Eating	☐	☐	☐	**Getting lost**	☐	☐	☐
Toileting	☐	☐	☐	**Recent memory**	☐	☐	☐
Finances	☐	☐	☐	**Early memory**	☐	☐	☐
Meal preparation	☐	☐	☐	**Solving problems**	☐	☐	☐

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4. Has the participant been hospitalized with the last year? Yes ☐ No ☐

   If yes, please explain reason _____

   _____

5. Has the participant been in a nursing home or long term care facility during the past year? Yes ☐ No ☐

   If yes, length of time _____
   Are they currently on a waitlist? _____

6. When was the participant last seen by a physician? _____
7. Please list all physical and mental illnesses the participant is currently being treated for

Physical/ Mental Illness	How long have they had this illness? *Circle*	
_____	_____	months years
_____	_____	months years
_____	_____	months years
_____	_____	months years
_____	_____	months years
_____	_____	months years
_____	_____	months years
_____	_____	months years

8. Specify how the participant usually spends most of his/her time (reading, sleeping, watching TV….)

   _____

   _____

9. Please fill in the background questions. This information will better able us to relate and take care of your loved one.

   Place of birth: _____

   Where lived most of life: _____

   Name of spouse: _____

   Name of children: _____

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Name of grandchildren: _____

Name of siblings: _____

Name of pets: _____

Other personal data: _____

10. Specify activities that the participant may be interested in _____

_____

11. How long did the participant attend school (degree)? _____

12. What was the participant's job/occupation? _____

13. What are your reasons for bringing the participant to WTMM Adult Day Health Care? _____

_____

_____

14. How did you hear about WTMM Adult Day Health Care? _____

_____

15. Please list any comments and problems related to mental/physical illnesses we should know (verbal abuse, combativeness, sound sensitivity and how you deal with it…]

_____

_____

_____

16. Monthly Schedule of Attendance:

WEEK 1	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time					
WEEK 2	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time					
WEEK 3	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time					
WEEK 4	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time					
WEEK 5	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time					

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17. Transportation will be provided by:
- ☐ Relative or Friend _____ (name)
- ☐ Public Transportation
- ☐ Day Care Program

ADVANCE DIRECTIVE NOTIFICATION

- ☐ My family member does not require a Power of Attorney (POA), may make his/her own medical or other decisions, and may sign for his/herself legally.
- ☐ My family member has a POA or legal guardian
  - Name of POA/guardian:_____
  - Phone number or POA/guardian: _____
- ☐ My family member has an advance directive
  - ☐ I will provide the daycare program with an original copy.
- ☐ My family does not have an advance directive.
  - ☐ I would like information on how to obtain an advance directive.
  - ☐ My family member does not want an advance directive.
- ☐ My family has a Do Not Resuscitate Order (DNR).

Print Name: _____ Phone No.: _____
Participant/Responsible Party

Signature: _____ Date: _____
Participant/Responsible Party

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PHYSICIAN REVIEW

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Day Care Participant's Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Date of last examination: _____

Diagnoses: _____

Is participant free of communicable/infectious disease or infection? Yes ☐ No ☐

Date of yearly TB Test: _____ Result: _____

Base Measures: _____ Pulse _____ Blood Pressure _____ Weight

Medications Please all medications taken by the participant. Attach additional sheet if necessary.

√ If taken at the Program	Can Participant Self-Administer	Medication Name	Dosage	Frequency	Route	Notes
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

These orders are in effect for six months unless otherwise specified.

May give PRN per directions on the bottle

_____ Acetaminophen _____ Lope amide _____ Antacid

_____ Ibuprofen _____ Cough Drops

Participant Ambulates: _____ Independently _____ With stand-by assist

_____ With cane _____ With walker _____ Is wheelchair bound

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PHYSICAL HEALTH STATUS

Disease/Condition	No	Yes	If yes, please comment
Arthritis, Rheumatism	☐	☐	
Asthma	☐	☐	
Emphysema, Chronic Bronchitis	☐	☐	
Tuberculosis	☐	☐	
High Blood Pressure	☐	☐	
Heart Condition	☐	☐	
HIV	☐	☐	
Circulation Problems	☐	☐	
Stomach Ulcers	☐	☐	
Diabetes	☐	☐	
Gastro-Intestinal Problems	☐	☐	
Urinary Tract Problems (include bladder incontinence)	☐	☐	
Anemia	☐	☐	
Effects of Stroke	☐	☐	
Epilepsy	☐	☐	
Glandular Disorders	☐	☐	
Allergies, Allergic Reactions	☐	☐	
Skin Disorders	☐	☐	
Communicable Diseases	☐	☐	
Other	☐	☐	

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Mental Status (Include history of mental illness and abnormal behavior)

- ☐ Loss of Appetite
- ☐ Insomnia
- ☐ Feeling of Worthlessness
- ☐ Loss of Interest
- ☐ Hypochondria
- ☐ Suspiciousness
- ☐ Hallucinations
- ☐ Delusions
- ☐ Distortion in Thinking
- ☐ Confusion
- ☐ Impaired Judgment
- ☐ Memory Loss
- ☐ Orientation Problem
- ☐ Hazardous Behaviors
- ☐ Alcohol Abuser
- ☐ Drug Abuser

Dietary Modifications: _____ No concentrated sweets _____ No Added salts

If additional modifications are needed a Diet Modification Order Form must be completed.

General Information

Does this person require constant supervision to make sure harm is not done to self, others or property? Yes ☐ No ☐

Will this person wander off if not closely attended? Yes ☐ No ☐

Can this person do light exercises from a sitting position, such as leg lifts, etc? Yes ☐ No ☐

Recommendations *I recommend and give approval for:*

_____ Social Activities _____ Therapeutic Work Activities _____ ADL Program

_____ Spiritual Activities _____ Modified Exercise Program _____ Recreational Activities

Please comment on any physical, mental or emotional condition apparent from your knowledge of the above named person than might need further explanation or might affect other participants.

_____

_____

Your signature below certifies that you have reviewed the health history and examined this person and find him/her able to participate in an adult day health care program.

Physician's Name (print) _____ Phone _____

Office Address: _____

_____

Physician Signature _____ Date _____

Information Release _____ Date _____

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DIET MODIFICATION ORDER FORM

(Submit for adults with special needs for meals.)

Date: _____

Participant's name: _____ **Male**____ **Female**____

Address: _____

_____

List the disability or medical condition that requires the participant to have a special diet or food.

Include a brief description of the major life activity affected by the participant's disability or reason for the food substitution ***(use back of the form if additional space is needed)***

_____

_____

_____

_____

_____

_____

_____

_____

Diet Prescription

List all foods that must be omitted
For milk allergies or intolerances to dairy products, please specify which dairy products must be avoided and also specify if milk as an ingredient in foods is okay (crackers, baked goods etc).

_____

_____

_____

_____

_____

List what foods can be substituted

_____

_____

_____

_____

_____

NOTE: If cow's milk must be avoided due to lactose intolerance or a non-severe milk allergy, lactose free milk or soy milk must be the substitution.