Living Better Adult Day Center

2060 Dorsett Village
Maryland Heights, MO. 63043

Admission Application

DATE_____

NAME_____ PHONE_____

ADDRESS_____

Date of Birth_____ Age_____ SEX: M_____ F_____

Social Security Number #_____ Marital Status_____

Name of Spouse, if applicable_____

Phone_____

Church Affiliation (optional) _____

Previous Occupation_____

Living Arrangements _____

Children #/Name _____

_____

Payment Source _____

Source of Referral _____

PERSONS TO CONTACT IN EMERGENCY

	Name	Relationship	Address	Phone
1.	_____			
2.	_____			

MEDICAL INFORMATION

Attending Physician _____

Address _____

Phone _____ Choice of Hospital _____

Advanced Directive _____ Yes _____ No (Please bring in copy for file if Yes)

Medical Diagnoses _____
_____
_____
_____

Diet Restrictions _____

Allergies _____

PHYSICAL FUNCTIONING AND NEEDS (check appropriate description)

Walking Ability: _____ Unassisted _____ Needs Assist

Assistive Device: _____ Cane _____ Walker _____ Wheelchair _____Prosthesis

Vision: _____ Good _____Glasses _____ Contacts _____Limited _____Blind

Hearing: _____Good _____Hearing Aid _____Hard of Hearing _____ Deaf

PERSONAL CARE

ASSISTANCE NEEDED: _____Bathing _____Toileting _____Eating _____Reading

_____Transferring _____Dressing

CONTINENCE: _____ Independent _____ Assistance (occasional accidents)

_____ Dependent (supervision needed or is incontinent)

MENTAL FUNCTION: _____Alert _____Confused _____Forgetful

Briefly describe applicant's mental status _____

_____

_____

SOCIAL AND EMOTIONAL FUNCTIONING

Describe how the client relates to others: _____

_____

_____

Activities Preferred (include hobbies, interests, and skills): _____

_____

_____

TRANSPORTATION NEEDS:

_____ Family/Individual provides _____ Needs Assistance with transportation

SCHEDULE PREFERRED:

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Hours of Attendance preferred _____

Signature of Applicant _____ Date _____

Signature of Responsible Party _____ Date _____

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize my physician, hospital, or other organization or person providing medical services to me to furnish such records, reports, or information to Living Better Adult Day Care Center. This information is necessary to provide pertinent medical information and physician approval for prescribed medication administration and/or other services prior to admission to the program or during my enrollment at Living Better Adult Day Care Center. I understand that in executing this authorization I am allowing for full disclosure of said medical information.

A photocopy of this authorization shall be considered as effective and valid as the original.

Participant Name: _____

Participant Signature: _____

Date of Birth: _____

Power of Attorney Signature (if applicable):

_____

Date: _____

LIVING BETTER ADULT DAY CENTER

EMERGENCY CONTACT INFORMATION

Name of participant: _____

Persons to contact in case of emergency:

Name:	**Relationship**	**Address**	**Phone**
1.			
2.			
3.			

Choice of Hospital: _____