CROUSE COMMUNITY CENTER, INC.
SHERBURNE ADULT DAY HEALTH CARE

VISITATION

Policy:

Crouse Community Adult Day Health Care shall permit registrants to have visitors at the center. Prospective registrants will also be afforded the opportunity to tour the program space during program hours.

Procedure:

1. Visitors shall be encouraged to notify the center when they would like to visit and whom.
2. The visitor shall inform the Program Director of whom he or she is visiting at the center when he or she arrives.
3. All visitors shall sign in at the center by completing the "Visitor Log".
4. The Program Director and the participant being visited shall approve the visit prior to allowing the person to visit.
5. Visitors are defined as those who would like to visit specific participant(s) in the center or as a prospective registrant touring the facility, such as:
   a. A family member or friend who is visiting for a short time;
   b. A friend or family member who would like to visit the participant in the center occasionally;
   c. A community resource representative who would like to visit/interview participant while at the center;
   d. A prospective registrant that may be accompanied by family/caregiver.
6. The Program Director may deny a visitor the opportunity to visit if the Program Director feels that the visitor or the visit may be detrimental to the participant's physical or emotional health. The Program Director shall document the reason for the denial in the "Visitor Binder".

Name: _____ DOB: _____

8. Current Medications and Dosage (include prescribed and over the counter medication):

_____

_____

_____

9. Do you know what each medication is for and why you are taking it? _____ If "no", please list the ones that you are unfamiliar with: _____

10. Do you have difficulty taking your medications (swallowing, mixing, figuring the dosage, etc.)? _____ If "yes", which ones? _____

11. Do you have difficulty remembering to take your medication? _____ If "yes", which ones? _____

12. Have you had any serious injuries or accidents?

_____

13. Do you smoke? _____ If "yes", how much? _____

Would you like to quit? Yes ( ) No ( )

14. Do you drink alcoholic beverages? Yes ( ) No ( )

If yes, how often? _____ How much? _____

15. Have you ever seen a physician or counselor for problems of depression, anxiety, or other psychological conditions? Yes ( ) No ( )

If yes, when? _____ For what? _____

16. Have you experienced any major life stressors in the last 90 days (Illness, death of someone close to you, loss of any kind)? _____

17. How long are you alone during the day? _____

18. Have you ever felt neglected abused, or mistreated?

_____

19. Were you ever a victim of a crime? _____

20. What is your highest level of education?

_____

21. Do you volunteer? _____

22. What is your employment status?

_____

Name: _____ DOB: _____

23. Do you have contact with close friends or family? _____ If so how often? _____

24. How would you rate your overall health? Good Fair Poor Uncertain

Symptoms

____ Made negative statements (Feels like nothing matters)
____ Persistent anger with self or others
____ Unrealistic fears (being abandoned, left alone)
____ Repetitive Health problems (Seeking medical attention)
____ Sad, pained or worried facial expression
____ Crying or tearfulness
____ Withdrawn from activities of interest
____ Reduced Social interactions
____ Feeling lonely
____ Wandering
____ Verbally abusive behavior
____ Physically abusive behavior
____ Socially inappropriate behavior
____ Resistive to care
____ Frequent falls, if so how many? ____
____ Injury from falls
____ Dizziness
____ Unsteady Gait
____ Chest pain
____ Delusions
____ Hallucinations
____ Acid Reflux
____ Diarrhea or constipation
____ Blood in your stool
____ Hemorrhoids
____ Nausea or vomiting
____ Difficulty falling asleep
____ Difficulty staying asleep
____ Sleeping too much
____ Inability to complete normal daily activities
____ Pain how often? _____ Where? _____

____ Unexplained weight loss
____ Poor short term memory
____ Poor long term memory
____ Easily distracted
____ Mental function changes throughout the day
____ Restlessness
____ Anxious or uneasy felling
____ Irritability
____ Obsessive thoughts
____ Compulsive behavior
____ Episodes of panic
____ Poor hygiene
____ Self-injurious behavior
____ Frequent or severe headache
____ Skin rashes
____ Open areas to skin Where? _____
____ Change in appetite
____ Fatigue
____ Swelling to ankles or feet
____ Nose bleeds
____ Chronic cough
____ Tremor or shakiness
____ Numbness or tingling or your feet, toes, or fingers
____ Shortness of breath
____
____

What does and doesn't help you pain symptoms? _____

_____

Name: _____ DOB: _____

Other serious illnesses:

_____

_____

_____

Additional comments:

_____

_____

_____

Functional Information

Please check the level of independence with the following activities of daily living:

	Independent	Some assistance	Total Assistance
Walking/Mobility			
Transferring			
Stair Climbing			
Public Transportation			
Eating			
Personal Care			
Bathing			
Dressing			

	Independent	Some assistance	Total assistance
Bladder Control			
Bowel Control			
Laundry			
House Keeping			
Cooking			
Shopping			
Taking Medication			
Paying Bills			

Do you use any mechanical aides? ( ) Cane ( ) Walker ( ) Wheelchair
( ) Brace ( ) Artificial Limb

Name: _____ DOB: _____

Crouse Community Center, Inc.
Adult Day Health Center

Admission Application and Assessment
(May be completed prior to admission or on day of admission)

Date of Assessment: _____

What name would you like us to call you? _____

1. Please list all of the physicians involved in your care:

Name of Physician	Specialty	Phone Number

2. Date of your last physician visit: _____

3. Have you had a physical within the last year? Yes ( ) No ( )

4. Date of most recent physical: _____

5. Please list recent hospitalizations: (leave blank if none)

Date	Hospital	Reason

6. List your current medical problems:

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

7. Do you have any allergies? _____ If "yes", please list and describe recreations:

_____

_____

Name: _____ DOB: _____

Bowel and Bladder

Please check all that apply:

Continent: _____ Bladder _____ Bowel _____ Catheter _____ Colostomy
Incontinent: _____Bladder _____Bowel _____ Briefs
How often do you urinate? _____ Do you have increased urination at night? _____
Do you have problems urinating (frequency, burning, pain, trouble starting)? Please explain

_____

How often do you move your bowels?

_____

Nutritional Information

1. Do you drink coffee? _____ Tea? _____ Cola drinks? _____
   How much per day? _____ _____ _____
2. Do you use table salt? _____
3. Do you need assistance eating? _____
4. Do you have difficulty swallowing? _____
5. Describe your usual diet below:

Breakfast: _____
Time: _____
Lunch: _____
Time: _____
Dinner: _____
Time: _____
Snacks: _____
Time: _____

6. Food likes and dislikes:

Likes: _____
_____
Dislikes: _____
_____

Please list foods you are allergic to:

_____
_____

7. Are you on a special diet? _____
   If yes, please describe: _____

Name: _____ DOB: _____

8. Do you have your meals prepared by someone else? _____ If yes, please explain:

_____

_____

9. Do you have a good understanding of your diet? _____ If yes, please specify what information you feel you need: _____

10. Have you lost your gained weight during the past year? _____ How much? _____

Please give possible reasons for weight loss or gain: _____

_____

Dental

1. Do you have: Dentures ( ) Partial Plate ( ) No teeth ( ) Missing teeth ( )
Broken or fragmented teeth ( ) Poor oral hygiene ( )
2. If you wear dentures or a partial plate, does it fit properly? _____
3. When was the last time you had a regular dental examination? _____
4. Who provides your dental care? _____
5. Do you have any difficulty chewing? _____ If yes, please explain: _____

_____

Vision

1. How well can you see?
Small print ( ) Large print ( ) Objects ( ) Light ( ) No vision ( )
2. Do you wear eyeglasses? Yes ( ) No ( )
3. Who provides your eye care? _____
4. When was your last appointment with your eye doctor? _____
5. Do you ever have blurry or double vision? Yes ( ) No ( )

Hearing

1. How is your hearing? Excellent ( ) Good ( ) Fair ( ) Poor ( )
Totally deaf ( )
2. Do you wear a hearing aid? Yes ( ) No ( )
If yes, do you wear it at all times? _____ Please explain: _____

_____

*Do you: Know American Sign Language ASL ( ) Know Signed English ( )
Read lips ( )

Name: _____ DOB: _____

Psycho-Social Information

1. Are you involved with any organized groups for socialization?

_____

_____

2. What are your hobbies, interests, and talents? Describe what you enjoy doing in your free time?

_____

_____

_____

3. What would you like to do more of/what would you like to engage in?

_____

_____

_____

4. What is most important to you? What makes you happy?

_____

_____

_____

_____

5. What are some of your challenges, fears or worries?

_____

_____

_____

6. What are some of your strengths and weaknesses?

S. _____

_____

W. _____

7. How could your health and wellness be improved?

_____

_____

Name: _____ DOB: _____

Additional Services

Will the following services be needed?

1. Hot meal Program (Meals on Wheels, etc.)
   Yes: _____ Comments: _____
   No: _____ Services provided by: _____
2. Assistance in paying bills (HEAP, Consumer Credit Counseling, etc.)
   Yes: _____ Comments: _____
   No: _____ Services provided by: _____
3. Domestic, Family, Marriage and/or Substance Abuse Counseling
   Yes: _____ Comments: _____
   No: _____ Services provided by: _____
4. Legal Services (Legal Services of CNY, etc.)
   Yes: ____ Comments: _____
   No: ____ Services provided by: _____
5. Companionship (Senior Companions, etc.)
   Yes: ____ Comments: _____
   No: ____ Services provided by: _____
6. Assistance with activities of daily living (home health aides, etc.)
   Yes: ____ Comments: _____
   No: ____ Services provided by: _____
7. Assistance with other routine chores (snow shoveling, lawn mowing, etc.)
   Yes: ____ Comments: _____
   No: ____ Services provided by: _____
8. Other services
   Yes: ____ Comments: _____
   No: ____ Services provided by: _____

Note: The above services may or may not be directly provided by Crouse Community Center's Adult Day Services Program. An appropriate referral will be made for those services that cannot be directly provided by Crouse Community Center's Adult Day Services Program.

Name: _____ DOB: _____

8. What are your goals for attending this medical adult day center?

_____

_____

9. What can we work on at program that would improve your quality of life?

_____

_____

Goals/Need/Strength and Preferences expressed by the participant or authorized representative based on the answers to the above questions:
1.
☐ Goal ☐ Need ☐ Strength ☐ Preference
2.
☐ Goal ☐ Need ☐ Strength ☐ Preference
3.
☐ Goal ☐ Need ☐ Strength ☐ Preference
4.
☐ Goal ☐ Need ☐ Strength ☐ Preference

Name: _____ DOB: _____

Functional Information

1. Please describe your current living arrangements (include others in your household):

_____

_____

_____

2. Is there one person you rely on more than any other? _____ Please explain:

_____

_____

3. Please list the agencies involved in providing care that visit you in your home:

_____

_____

_____

4. Do you require special environmental modifications to live comfortably? (TTY device, ramp to front door, railings in shower, etc.) If yes, please describe what modifications you need:

_____

_____

_____

Additional comments:

_____

_____

_____

Application Completed by:_____ **Date:**_____

_____ **Date:** _____

Relationship to applicant: _____