UCFS Eldercare

Inquiry Date: _____
Trial Visit Date: _____
Adm. Date: _____

ROSS ADULT DAY CENTER
INTAKE APPLICATION

Prefers to be called _____

Name _____ Telephone _____

Address _____ Date of Birth _____

Sex: Male _____ Female _____ Race _____ Birthplace _____

Marital Status: _____ Referral Source _____

Social Security # _____

Medicare # _____ Other Insurance # _____

Diagnoses Medications/Dosage

_____

_____

_____

_____

Physician _____

Cognition (circle) Alert, Forgetful, Confused, Depressed, Other:_____

Mobility (circle) None, Cane, Walker, Wheelchair, Other: _____

Diet _____

Allergies _____

Meals: (circle) Independent Requires Assistance Feed Dentures Ground Set-Up

Continence: Bowel _____

Bladder _____

Toileting: (circle) Independent Requires Assistance Remind Skin: (circle) Intact Open area(s)

Speech _____ Hearing _____ Vision _____

Emergency Contact:

Name _____ Relationship _____

Address _____ Telephone_____

Family History/Information _____

_____

_____

Living Arrangements: (circle) House Apartment Group Home RCH Left Alone:

(circle) Alone w/family w/non-family Yes ___ No ___

Former Occupation_____

Religious Affiliation_____

Other Supportive Services or Programs Receiving _____

_____

Days Scheduled _____ Transportation _____

Payment _____

White – Chart Yellow - Director