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.

Birth date _____

Height _____ Weight _____ Sex: ☐ Male ☐ Female ☐ Other

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:_____ Cell Phone:_____ Work Phone:_____

Work Place:_____Email:_____

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: _____

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

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Applicant_____ **Caregiver**_____

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

Name:_____Relationship toApplicant:_____

Address:_____

_

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

Work Place:_____Work Hours:_____

Work Phone: _____

E-mail:_____

Name:_____Relationship toApplicant:_____

Address:_____

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

Work Place:_____Work Hours:_____

Work Phone: _____

E-mail:_____

Primary Physicians – Hospital Preference

Doctor's Name:_____

Hospital Preference:_____

Applicant Assessment

If you answer yes, please explain.

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

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

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Applicant_____ **Caregiver**_____

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: ☐ No Impairment ☐ Wears Glasses

Dentures: ☐ Yes ☐ No

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

Walking:

Without any help ☐ Yes ☐ No

With some help ☐ Yes ☐ No Explain:_____

☐ Cane ☐ Walker ☐ Wheelchair

Eating:

☐ Without Help ☐ Needs to be prompted to eat ☐ Eats too fast

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: _____

Toileting
Bowel and Bladder:

Incontinence of Bladder: ☐ Yes ☐ No

Incontinence of Bowel: ☐ Yes ☐ No

Products Used in Daytime: ☐ Nothing ☐ Panty Liners ☐ Pads ☐ Adult Diapers

Help Required: ☐ None ☐ Reminders ☐ Physical Assistance

Behavior (Please check ALL that apply)

Communication

☐ Difficulty communicating wants and needs

☐ Sentences do not make sense

☐ Difficulty naming people

☐ Has difficulty concentrating on a task or activity

☐Takes little or no interest in activities and will not start them by self

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Applicant_____ **Caregiver**_____

☐ Often asks the same questions over and over again

☐ Loses or misplaces objects

☐ Has difficulty following simple directions

☐ Wanders away from home:_____

☐ 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 agitated When:_____

☐ Engages in embarrassing or socially inappropriate behavior How:_____

☐ 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

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_____

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Applicant_____ **Caregiver**_____

Applicant Interests (Current and past)

Previous Occupation:_____Work Place:_____

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

How does the applicant currently spend his/her day?

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

_____

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Fax return to: (865) 483-4391
Date: _____
TO: _____
MD Fax: _____

Medical Examination

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: _____
(Doctor, Hospital, or Health Department)

Address: _____
Address City/State Zip Code

I hereby authorize and request you to release to:

Keystone Adult Day Program
1350 Oak Ridge Turnpike
Oak Ridge, TN 37830

Name: _____
(Patient)

Address:

_____
Address City/State Zip Code

Medical Records and /or other information concerning my illness and/or treatment of _____

Sign Here: _____Date:_____
(Participant of Responsible Party)

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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 its work, reproductions of my likeness by photographic or electronic media means (social media, television and 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 your family member's eligibility for the program.

Sign Here: **Signature** **Date**

_____ _____
Participant

And/Or: **#4 Signature** **Date**

_____ _____
Caregiver/Responsible Party

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MEDICATION RECORD

Date_____ Allergies_____

Participant Name_____

Signature of Responsible Party_____

DATE ORDERED	MEDICATION	REASON	DOSAGE	TIME	PHYSICIAN