Saint Francis Adult Day Health Center
101 Plantation Street
Worcester Ma 01604
Phone (508) 752-2546/Fax (508) 471-2269

PHYSICIAN'S STATEMENT

Name of applicant: _____ *DOB:* _____
Temperature: _____ *Pulse:* _____ *B/P:* _____
Weight: _____ *Height:* _____

Diagnosis:

Please list name and dosage of all medication patient is receiving:

Allergies: _____ *Yes* _____ *No*
If yes to what
What is the reaction?

Specific Diet: _____ *Yes* _____ *No*

Consistency of food: *Regular* *Ground* *Pureed*
Consistency of fluid: *Thin* *Honey* *Nectar*

Date of last physical examination. (Within three months) _____

PPD Test:
Date _____ *Results:* _____

(PPD required within one year prior to admission)

Mental/Emotional Impairments? _____ *Yes* _____ *No*
Functional limitations/Assistive Devices? _____ *Yes* _____ *No*
Restrictions on participants in activities? _____ *Yes* _____ *No*
Recent illnesses or hospitalizations? _____ *Yes* _____ *No*
(Within three months).
Is participant capable of self-monitoring medications? _____ *Yes* _____ *No*

Are there any abnormalities of: (record details under explanatory remarks below)

General appearance: _____ *Yes* _____ *No*
Skin Condition: _____ *Yes* _____ *No*
Reflexes: _____ *Yes* _____ *No*
Eyes: _____ *Yes* _____ *No*
Blood Vessels: _____ *Yes* _____ *No*
Throat: _____ *Yes* _____ *No*
Lips: _____ *Yes* _____ *No*
Teeth: _____ *Yes* _____ *No*
Chest: _____ *Yes* _____ *No*
Lungs: _____ *Yes* _____ *No*
Heart: _____ *Yes* _____ *No*
Nose: _____ *Yes* _____ *No*
Breasts: _____ *Yes* _____ *No*
Abdomen: _____ *Yes* _____ *No*
Genitals: _____ *Yes* _____ *No*
Rectum: _____ *Yes* _____ *No*
Bones: _____ *Yes* _____ *No*
Tongue: _____ *Yes* _____ *No*
Joints: _____ *Yes* _____ *No*
Mouth: _____ *Yes* _____ *No*
Muscles: _____ *Yes* _____ *No*
Gums: _____ *Yes* _____ *No*
Upper Extremities: _____ *Yes* _____ *No*
Neck: _____ *Yes* _____ *No*
Lower: _____ *Yes* _____ *No*
Lymph Nodes: _____ *Yes* _____ *No*
Neurological System: _____ *Yes* _____ *No*

Additional & Explanatory remarks:

Flu shot yearly _____*Yes* _____*No*
If yes date of flu vaccine: _____
Screening is available for special therapies: *(Please check appropriate area)*

*Physical Therapy*_____ *Speech Therapy*_____ *Occupational Therapy*_____

Nursing intervention and special dressings: *(please indicate treatment if needed)*

Alternate physician replacing you in case of absence or emergency:

_____*M.D.*
Signature of attending physician
*NPI #*_____
*DATE:*_____

Name: _____

Address: _____

Telephone: _____ *Fax:*_____

Saint Francis Adult Day Health Center
101 Plantation Street
Worcester, Ma 01604
(508) 752-2546 A.D.H / (508) 775-8605 Nursing Home
FAX (508)471-2269

ADMISSION APPLICATION

Date: _____

Name: _____ Sex: Male _____ Female _____
Last First Middle

Address: _____ Telephone _____
Number Street

_____
City Zip Code

I Live in: _____ Own Home
_____ Apartment
_____ Rooming House
_____ Other

I Live With: _____ Spouse
_____ Children
_____ Relatives
_____ Other
_____ Alone

Date of Birth: _____ Birthplace: _____ Age: _____

Languages Spoken: _____ Religious Preference: _____

Former Occupation or trade: _____ Date of retirement: _____

Marital Status (Check): _____ Married _____ Single _____ Widowed
_____ Divorced _____ Separated

My Spouse's Name is: _____
Or
If widowed, give name of deceased and date of death

_____

Number of children: Sons_____ Daughters_____

Interested / responsible persons to be notified in case of illness / emergency

Name: _____ *Relationship:* _____

Address: _____ *Telephone: Home* _____

_____ *Business:* _____

Name: _____ *Relationship:* _____

Address: _____ *Telephone: Home* _____

_____ *Business:* _____

Physician's Name: _____ *Telephone:* _____

Address: _____

Date of last visit: _____ *Date of the last physical exam:* _____
(It is required that an applicant have a physical examination by a physician within three months prior to admission to the program.)

ACTIVITIES OF DAILY LIVING

Mentally Alert: _____ *Forgetful:* _____ *Confused:* _____

Ambulation: _____ *In and out of car* _____ *Transfer chair to toilet*
_____ *Walk unassisted* _____ *Aids,canes,crutche,walker*
_____ *Climb stairs* _____ *Manage wheelchair*

Bladder functioning: _____ *Continent* _____ *Incontinent*
Bowel Functioning: _____ *Controlled* _____ *Involuntary*

Self Care: _____ *Feeds Self:* _____ *Special Diet:* _____

Special interests – Hobbies – How applicant spends day:

_____

_____

_____

Social Security Number: _____

Medicare Number: _____ *Plan A B (circle 1 or both)*

Other health insurance: _____

(Medex,Fallon,CMHC etc. Please specify) include numbers

Are you a recipient of Medicaid (Mass health)? _____ *Yes* _____ *No*

If yes, Medicaid Number _____

Reasons for application to Adult Day Health:

_____

_____

_____

Please check which days you would prefer to attend:

Monday _____ *Tuesday* _____ *Wednesday* _____ *Thursday* _____ *Friday* _____

Do you have a health care proxy? _____ *Yes* _____ *No*

Do you receive services from other agencies? _____

_____ *VNA*
_____ *Elder Home Care*
_____ *Dept.Mental Health*
_____ *Other – Please list.*

Signature of applicant : _____

Signature of person making application other than applicant :

_____

(Specify relationship or agency affiliation)

All applicants will have a visit to the center arranged by the Adult Day Health Program staff prior to admission.

Directions to applicant's home:

_____

_____

_____

Front or Rear Door _____