

# King Lunalilo Adult Day Care Center

## APPLICATION FOR DAY CARE SERVICES

NAME \_\_\_\_\_ DATE OF APPLICATION \_\_\_\_\_  
*Last First Middle*

BIRTHDATE \_\_\_\_\_ SEX \_\_\_\_\_ SSN \_\_\_\_\_ MARTIAL STATUS  S  M  W  D

BIRTHPLACE \_\_\_\_\_ ENTRY TO USA \_\_\_\_\_ U.S. CITIZEN?  YES  NO

ETHNICITY \_\_\_\_\_ LANGUAGES SPOKEN \_\_\_\_\_

REFERRED BY/FROM \_\_\_\_\_ RELIGIOUS AFFILIATION \_\_\_\_\_  
*Individual/Agency/Society*

DAY SERVICES REQUESTED:  MONDAY  TUESDAY  WEDNESDAY  THURSDAY  FRIDAY

CURRENT MAILING ADDRESS \_\_\_\_\_  
*Number/Street City State Zip*

NEXT OF KIN, 1. \_\_\_\_\_  
PRIMARY CAREGIVER OR 2. \_\_\_\_\_  
PERSON RESPONSIBLE 3. \_\_\_\_\_  
*NAME RELATIONSHIP*

ADDRESS (ES) OF ABOVE 1. \_\_\_\_\_ Ph. \_\_\_\_\_  
2. \_\_\_\_\_ Ph. \_\_\_\_\_  
*Number/Street City, State, Zip*

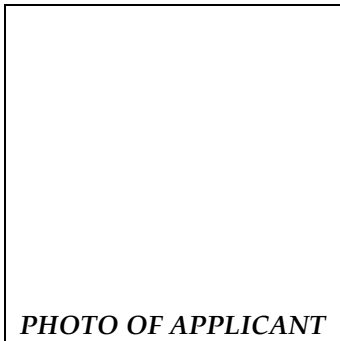
FOOD ALLERGIES \_\_\_\_\_

PRIMARY DIAGNOSES/CHRONIC CONDITION \_\_\_\_\_

HEALTH INSURANCE CARRIER & NUMBER \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_

PHYSICIAN'S PHONE \_\_\_\_\_



RESPONSIBLE PERSON'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

FOR OFFICE USE ONLY	
_____ PE COMPLETED	INTERVIEW/EVALUATION DATE _____ REVIEW DATE _____
_____ TB CLEARANCE	OTHER INFORMATION REQUIRED _____
_____ DIET ORDER	START DATE _____ OR REASON REFUSED _____
ASSESSMENT BY: _____	

PARTICIPANT PHYSICAL EXAMINATION FORM (CONFIDENTIAL)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex  M  F

MEDICAL FINDINGS (To be completed by Physician or Records Librarian)

Weight \_\_\_\_\_ Height \_\_\_\_\_

Eyes \_\_\_\_\_  
Vision without glasses Rt. 20/ Lt. 20/ with glasses Rt. 20/ Lt. 20

Ears \_\_\_\_\_ Hearing: Rt. \_\_\_/20 Lt. \_\_\_/20

Mouth, throat and nose: \_\_\_\_\_

Lungs \_\_\_\_\_ Dyspnea \_\_\_\_\_ Cyanosis \_\_\_\_\_

Heart and circulatory system: \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse Rate \_\_\_\_\_

Abdomen \_\_\_\_\_

Genito-urinary and gynecological \_\_\_\_\_

Continence status \_\_\_\_\_ Type \_\_\_\_\_

Rectal \_\_\_\_\_

(Hemorrhoids, etc.)

Extremities \_\_\_\_\_ Edema \_\_\_\_\_

Nervous system \_\_\_\_\_

Psychiatric and/or Psychological findings \_\_\_\_\_

Other conditions \_\_\_\_\_

Substantiating laboratory findings \_\_\_\_\_

DIAGNOSIS

Primary \_\_\_\_\_

Secondary \_\_\_\_\_

Current Medications \_\_\_\_\_

Present medical treatment \_\_\_\_\_

Activities to be avoided \_\_\_\_\_

Appropriate for Adult Day Services  YES  NO

2 Step TB Clearance \_\_\_\_\_

Vaccines \_\_\_\_\_ Date \_\_\_\_\_

Pneumovax \_\_\_\_\_

Influenza \_\_\_\_\_

Tetanus \_\_\_\_\_

Examiner's name \_\_\_\_\_

Date of Examination \_\_\_\_\_

Examiner's signature \_\_\_\_\_

# DIET ORDER REQUEST

DATE \_\_\_\_\_

RE: \_\_\_\_\_

*Participant*

1. **Regular Diet**  
 Regular     Chopped  
 Minced     Pureed
  
2. **No Concentrated Sweets Diet (Therapeutic)**  
 Regular     Chopped  
 Minced     Pureed
  
3. **Low Sodium Diet (Therapeutic) 2 grams of sodium**  
 Regular     Chopped  
 Minced     Pureed
  
4. **No Added Salt (Therapeutic) 4 grams of sodium**  
 Regular     Chopped  
 Minced     Pureed
  
5. **Other:** \_\_\_\_\_
  
6. **Thicken Liquids**  
 Nectar     Honey     Pudding

Please list known food allergies \_\_\_\_\_

Diet Drug Interactions \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Other Comments** \_\_\_\_\_

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*PHYSICIAN'S RECORD*

NAME OF PARTICIPANT \_\_\_\_\_

<i>DATE</i>	<i>PHYSICIAN'S EXAMINATION AND ORDERS</i>	<i>SIGNATURE &amp; CLINIC</i>

## "GETTING TO KNOW YOU"

APPLICANT: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

To find out if you or the applicant would benefit from the type of services our day care offers, please mark "X" in the appropriate column. **There are no right or wrong answers.**

DESCRIPTIVE STATEMENT	YES	NO
<i>Is alert and aware of his/her surroundings.</i>		
<i>Gets lost or wanders away more than once a week.</i>		
<i>Should not be left alone at all.</i>		
<i>Walks slowly, but without help of any kind.</i>		
<i>Uses cane or walker to walk around.</i>		
<i>Must be fed by another person.</i>		
<i>Able to feed self or uses assistive eating ware.</i>		
<i>Needs help of another person to get out of bed.</i>		
<i>Does not walk, usually stays in bed or room.</i>		
<i>Able to go to bathroom by self.</i>		
<i>Has frequent bladder/bowel accidents, uses protective undergarments.</i>		
<i>Can take care of toilet needs when reminded.</i>		
<i>Has a skin sore or ulceration.</i>		
<i>Under doctor's care for medical condition.</i>		
<i>Is taking medicine/medication by injection.</i>		
<i>Is hard of hearing, has poor eyesight or both.</i>		
<i>Is sometimes forgetful but less than twice a week.</i>		
<i>Unable to remember beyond five (5) minutes.</i>		

Additional Comments: \_\_\_\_\_

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