THE UCMJ ADULT DAY ACTIVITY CENTER

6089 Apple Tree Drive
Memphis, TN 38117
(phone)901-619-1200
email: ucmjadac@gmail.com

CLIENT APPLICATION TO BE SUBMITTED PRIOR TO ADMISSION INTERVIEW

Client Information

Full Name _____ Preferred Name to be called _____

Address _____

City / State / Zip Code _____ Phone _____

Birth date____/_____/_____ Age _____ Height _____Weight _____

Gender: ☐ Male ☐ Female

Primary Language _____ Other Languages Spoken_ _ _ _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Responsible Party Information/Primary Caregiver

Name _____ Relationship to Client _____

Address _____

City / State / Zip Code _____ Home Phone _____

Work Place _____Work Phone _____

Email address _____ Cell Phone _____

(Please circle or (*) your preferred contact phone number)

Does the primary caregiver live with the applicant? ■ Yes If No
No, living arrangements: Spouse

☐ Lives alone ☐ ☐ Relative ☐ Hired caregiver ☐Other _____

Is the primary family caregiver employed?
☐ Full time ☐ Part time ☐ Does not work outside the home ☐ Will work in the future

Has the applicant attended an Adult Day Program before?
☐ Yes ☐ No

Preferred days for applicant to attend our center:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Flexible

How did you learn about our program? _____

Does the applicant have Long Term Care Insurance? ☐ Yes ☐ No

Medical Information and Hospital Preference

Doctor's Name _____ Specialty _____

Address _____ Phone Number _____

City, State _____ Hospital Preference _____

Last time hospitalized _____ Reason _____ Length of Stay _____

Will the applicant require assistance with medication while at the Center? ☐ Yes ☐ No

Is the applicant allergic to anything (medications, foods, latex gloves, insect stings, etc.)?

☐ No ☐ Yes If Yes, what? _____

Does the family feel they understand the diagnosis of the applicant? ☐ Yes ☐ No

If No, what would you like to know? _____
_____
_____

Has the individual/family completed a:

☐ Durable Power of Attorney ☐ Advanced Directive ☐ Conservatorship
☐ POST Order (Do Not Resuscitate) ☐ Living Will

***If any of the above are marked, please provide a copy of the documents.**

Emergency Contacts and Persons Authorized to transport, sign in and sign out a client (other than primary caregiver). Please note: only a person who is 16 years or older may sign in or out a client. Please let us know if any of these phone numbers change.
We respect and protect the privacy of the information below.

Client Name: _____

Name/Address	Phone number	Email (For use only in emergency and/or periodic communication.)	Relationship to the applicant

Client Assessment Data

Pleasebe as thorough/specific as you can.

Diagnosis of memory impairment:
Memory impairment? ☐ Yes ☐ No
Date of diagnosis of dementia _____ Physician who made the diagnosis _____
Is the client aware of the diagnosis? ☐ Yes ☐ No
Specific Diagnosis _____
Briefly describe the onset of dementia and how the applicant and family responded to these changes:

_____
_____
_____

Hearing Impairment:
Right Ear: ☐ No loss ☐ Some loss ☐ Complete loss ☐ Hearing Aid ☐ Refuses to wear
Left Ear: ☐ No loss ☐ Some loss ☐ Complete loss ☐ Hearing Aid ☐ Refuses to wear

Visual Impairment:
Right Eye: ☐ No impairment ☐ Cataracts ☐ Implants ☐ Other:
Left Eye: ☐ No impairment ☐ Cataracts ☐ Implants ☐ Other:
Glasses: ☐ Yes ☐ No ☐ Does not wear, explain _____

Dentures: ☐ Yes ☐ No
Upper: ☐ Full ☐ Partial ☐ No teeth ☐ Removable bridge
Lower: ☐ Full ☐ Partial ☐ No teeth ☐ Removable bridge

Walking:
Steady on his/her feet: ☐ Yes ☐ No
Needs some help: ☐ Yes ☐ No Please explain _____
Assistive Equipment:
☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ One to one assistance

Diet:
☐ Regular ☐ No extra sugar ☐ No extra salt ☐ Other restrictions _____

Appetite:
☐ Good ☐ Poor ☐ Varies ☐ Eats too fast Other information _____

Eating:
☐ Without help ☐ Some help_____ ☐ Needs prompting to eat.
Please explain
Other considerations and food favorites or dislikes _____
_____

Swallowing:

Does the applicant have problems swallowing his/her food? ☐ Yes ☐ No
Does the applicant store food in his/her mouth? ☐ Yes ☐ No
Does the applicant have problems with choking? ☐ Yes ☐ No
If yes, are there certain foods that cause choking? _____

Favorite morning beverage? ☐ Coffee ☐ Hot tea ☐ Juice ☐ Water Other _____

Has there been any recent ☐ Weight loss ☐ Gain ☐ Neither Amount: _____lbs.

Does he/she smoke or vape? ☐ Yes ☐ No *(Please note that we are a smoke/vape free facility)*

Toileting:

Incontinent of bladder: ☐ Yes ☐ No ☐ Nighttime only
Incontinent of bowel: ☐ Yes ☐ No ☐ Nighttime only
Products used in daytime: ☐ Nothing ☐ Liners ☐ Pads ☐ Disposable underwear

Help required: ☐ None ☐ Reminders ☐ Physical Assistance ☐ Positioning ☐ Supervision ☐ Changing disposable garments

If a wheelchair and physical assistance are used, is the applicant able to stand and support his/her weight long enough to safely transfer to the toilet (abt 2 min.)? ☐ Yes ☐ No

Dressing:

Helprequired: ☐ None ☐ Lay out clothing ☐ Verbal cuing ☐ Physical assistance Other: _____

Bathing/showering:

Help required: ☐ None ☐ Verbal cuing ☐ Physical assistance

Level of Conversation/Language (Please circle yes or no**):**

☐ Yes ☐ No: Isable to converse in most social situations
☐ Yes ☐ No: Uses full sentences with descriptive details
☐ Yes ☐ No: Can communicate basic wants and needs
☐ Yes ☐ No: Understands directions for activities (to dress, eat, go outside, etc.)
☐ Yes ☐ No: Can recall most recent events and conversations
☐ Yes ☐ No: Can name family members they see regularly
☐ Yes ☐ No: Sentences do not make sense, may ramble
☐ Yes ☐ No: Often asks the same questions or tells the same stories over and over again

Behavior: please check all that apply

☐ Confusion about current eventsin their life, confusion about time and place
☐ Problems with judgment: making important decisions, can't handle major life decisions
☐ Difficulty concentrating on a task or activity
☐ Takes little or no interest in activities and will not start them by self
☐ Becomes anxious in noisy environments Hoards objects
☐ Wanders away from home: # of times ____
☐ Wears a Medic Alert or ID bracelet? Yes or No

☐ Cannot be left at home alone, must be supervised
☐ Requires constant attention and will not let you out of sight
☐ Becomes verbally aggressive When _____
☐ Becomes physically aggressive When _____
☐ Becomes anxious When _____
☐ Are there any words/subjects that upset him/her? Please explain _____
_____
☐ Engages in embarrassing and socially inappropriate behavior. What? _____
_____
☐ Talks to people he/she does not know
☐ Denies or seems unaware that anything is wrong
☐ Reports seeing or hearing things that are not there
☐ Has episodes of paranoia Please explain _____
☐ Appears depressed
☐ Afraid of dogs
☐ Engages in behavior that is potentially dangerous to self or others; Please explain _____
_____

Please list any other behaviors/habits or challenges that would be helpful for us to know.

Personality:
Before onset of illness _____ Current_____

Current patterns of relating to others: ☐ Outgoing ☐ Social ☐ Quiet ☐ Solitary

Does the applicant read? ☐ Yes ☐ No If Yes, what? _____

Does the applicant write? ☐ Yes ☐ No

Favorite things/Preferences and Life Experiences: (Please note; this information will help us to understand and share conversation with the applicant.)

Place of Birth _____

If adopted, please give pertinent information here:

_____
_____

Places applicant lived as a child and as an adult:

_____
_____

If applicable, Cultural background

_____

Memories/activities most often talked about:

_____
_____
_____

Highest level of education: ☐ 8th grade ☐ High School ☐ College ☐ Other: _____

Name and place of high school _____
If applicable, name of college _____ Major _____

Veteran: ☐ Yes ☐ No Service _____ Eligible for VA benefits? ☐ Yes ☐ No
Branch _____
Rank _____

If a veteran, where did the applicant serve and what did they do?

_____
_____

Brief work history (places of employment, types of jobs, age of retirement, etc):

_____
_____
_____

Marital history (divorces, separations, spouse's passing):_____

_____
_____

Names of children and the most important people in the applicant's life:

_____
_____
_____

History of alcohol/drug abuse: _____
_____

History of traumatic events (abuse, war, tragedy, abandonment): _____
_____
_____

History of brain trauma: _____
_____

Personal Interests:

Favorite vacations: _____
_____

Faith-based activities and/or community service work: _____
_____
_____

Faith-based habits/rituals/beliefs that would be important for us to know (religious affiliation):

_____
_____

Hobbies/Interests: _____
_____
Art Experiences/Talent: _____
_____

Music Experiences: Did/does the applicant play an instrument? Sing in a group? Play in a band? Dance? Other? _____

What music did they and/or do they like to listen to? Favorite song(s)?
_____
_____

What genre of music did they like as a teenager or young adult? _____
_____

Favorite reading materials, poems, stories, authors, magazines, etc.?
_____

How did he/she spend their leisure time prior to the onset of dementia or frailty?
_____

Which of these things can they still do? _____
_____

How does the applicant currently spend their time during the day?
_____

What is special about this applicant that you would like us to know?
_____
_____
_____
_____

Family Long Term Plan of Care:
Do you need information about:

- ☐ Long Term Care facilities
- ☐ Respite Care
- ☐ In Home Care Services
- ☐ Physicians
- ☐ Attorneys
- ☐ Geriatric Case Managers
- ☐ Hospice
- ☐ Other

Name of person completing this form _____

Date _____ Relationship to the applicant _____

The UCMJ Adult Day Activity Center
6089 Apple Tree Drive
Memphis, TN 38117
901-612-1400 (phone)
ucmjadac@gmail.com

TREATMENT FORM

Name _____ Date of Birth _____

Address _____

_____

Gender _____ Marital Status _____ Age as of admit date _____ Eye Color _____

Responsible Party/Caregiver _____ Home Phone _____

Relationship to client _____ Work Phone _____

Home Address _____ Caregiver's Place of Work _____

_____ Cell Phone _____

2nd Name for Emergency _____ Home Phone _____

Address _____ Work Phone _____

Cell Phone _____

Physician _____ Phone _____

Hospital Preference _____ Allergies _____

DNR (Do Not Resuscitate Order) or POST provided to the Center**:** ( ) Yes *Date provided _____ ( ) No

Diagnosis: _____

_____

_____ _____

Responsible Party Date completed

Please initial below if in agreement.

The above signed have understood and agreed that The UCMJ Adult Day Activity Center cannot be responsible for routine medical maintenance, care or consultation and that all arrangements for any medical problem or special physical or medical needs shall be the sole responsibility of the caregiver, guardian or responsible party. ___ The above responsible party provides permission to The UCMJ Adult Day Care Activity Center to provide this Emergency Treatment Form, a DNR or POST (if available), and medical form to emergency personnel in case of an emergency.