Mailing Address
3185 Hickory Hill Road
Memphis, TN 38115-2533
www.alzheimersdayservices.org
(901) 372-4585
(901) 370-5642

Keeping Families Together - for over 28 years!

Two Locations:	
Louis E. Grashot Center 4585 Raleigh LaGrange (In Kennedy Park) Memphis, TN 38128-6413	Dorothy's Place 3185 Hickory Hill Road (Hickory Hill and Knight Arnold Road) Memphis, TN 38115-2533

Applicant General Information

Name: ______________________ Preferred Name to Be Called: ______________________

Address: ____

City / State / Zip Code: ______________________ Phone: ______________________

Applicant Personal Information - This information will remain confidential.

Social Security Number: XXX-XX- ________ Medicare Number: XXX-XX- ______ Birth Date:____/____/____

Age: __________ Height: __________ Weight: __________ Sex: ☐ Male ☐ Female

Applicant Preferences **(Please Check)**

Preferred Center: ☐Grashot/Raleigh LaGrange ☐Dorothy's Place/Hickory Hill Desired # of Days: __________

Preferred Days: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Any Day ☐ First Available

Primary Caregiver or Responsible Person Information

Name: ______________________ Relationship to Applicant: ______________________

Address: ____

City / State / Zip Code: ______________________ Home Phone: ______________________

Work Place: ______________________ Work Hours: ______________________

Work Phone: ______________________ Pager Number: ______________________

Mobile Phone: ______________________ Other Phone: ______________________

E-mail: ____

Is the billing address the same? ☐ Yes ☐ No (If no, please provide correct information below.)

Billing Name: ____

Billing Address: ______________________ City /State / Zip Code: ______________________

How did you find out about Alzheimer's Day Services? ______________________

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Applicant ______________________ **Caregiver**______________________

Advance Directives

☐ Power of Attorney ☐ Living Will ☐ Do Not Resuscitate ☐ None ☐ Other ____________________

Power Of Attorney's Name: ______________________

For office use only:

Please furnish Alzheimer's Day Services with a copy of any that may apply.

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

Name: ______________________ Relationship to Applicant: ______________________

Address: ______________________ City / State / Zip Code: ______________________

Home Phone: ______________________ Work Place: ______________________

Work Hours: ______________________ Work Phone: ______________________

Other Number: ______________________ Mobile Phone: ______________________

E-mail address: ______________________

For office use only:

Name: ______________________ Relationship to Applicant: ______________________

Address: ______________________ City / State / Zip Code: ______________________

Home Phone: ______________________ Work Place: ______________________

Work Hours: ______________________ Work Phone: ______________________

Other Number: ______________________ Mobile Phone: ______________________

E-mail address: ______________________

For office use only:

Name: ______________________ Relationship to Applicant: ______________________

Address: ______________________ City / State / Zip Code: ______________________

Home Phone: ______________________ Work Place: ______________________

Work Hours: ______________________ Work Phone: ______________________

Other Number: ______________________ Mobile Phone: ______________________

E-mail address: ______________________

For office use only:

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Applicant ______________________________ **Caregiver** ______________________________

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

Name: ______________________ Relationship to Applicant: ______________________

Address: ______________________ City / State / Zip Code: ______________________

Home Phone: ______________________ Work Place: ______________________

Work Hours: ______________________ Work Phone: ______________________

Other Number: ______________________ Mobile Phone: ______________________

E-mail address: ______________________

For office use only:

Name: ______________________ Relationship to Applicant: ______________________

Address: ______________________ City / State / Zip Code: ______________________

Home Phone: ______________________ Work Place: ______________________

Work Hours: ______________________ Work Phone: ______________________

Other Number: ______________________ Mobile Phone: ______________________

E-mail address: ______________________

For office use only:

Primary Physicians - Hospital Preference

Doctor's Name: ______________________ Doctor's Name: ______________________

Specialty: ______________________ Specialty: ______________________

Address: ______________________ Address: ______________________

City/State/Zip: ______________________ City/State/Zip: ______________________

Phone: ______________________ Phone: ______________________

Hospital Preference:______________________ Last Time Hospitalized: ______________________

Reason: ______________________ Length of Stay: ______________________

Long-term effects: ____

Safe Return Information

Is the Applicant registered in this national program for possible wanderers? ☐ Yes ☐ No

If you answer yes, please record registration number here: ______________________.

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Applicant ________________________________ **Caregiver**________________________________

Applicant Assessment

If you answer yes, please explain.

Has there been any recent ☐ Weight loss? ☐ Gain? ☐ No Amount: _________lbs. How Long:________________________

Are there any Drug Allergies: ☐ Yes ☐ No What Drugs: _____________ Type of Reaction:______________

Are there any Food Allergies: ☐ Yes ☐ No What Foods: _____________ Type of Reaction:______________

Does He/She Smoke/Chew/Dip: ☐ Yes ☐ No How Much?: ____

Can the Applicant Read? ☐ Yes ☐ No

Does the Applicant Write? ☐ Yes ☐ No

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:

Left Eye: ☐ No Impairment ☐ Cataracts ☐ Implants ☐ Other: ________________________________

Right Eye: ☐ No Impairment ☐ Cataracts ☐ Implants ☐ Other: ________________________________

Glasses: ☐ Reading ☐ Distance ☐ Bifocals ☐ Does not wear, explain: ____________________

Dentures: ☐ Yes ☐ No

Upper: ☐ Full ☐ Partial ☐ No Teeth ☐ Removable bridge ☐ No Teeth

Lower: ☐ Full ☐ Partial ☐ No Teeth ☐ Removable bridge ☐ No Teeth

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

Walking:

Steady on his/her feet ☐ Yes ☐ No

Without any help ☐ Yes ☐ No

With some help ☐ Yes ☐ No Explain: ____

☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Supervised walking ☐ One to one assistance

Eating:

☐ Without Help ☐ Some Help____ ☐ Needs to be prompted to eat

Please explain

Other considerations: ____

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________________________________

Appetite:

☐ Good ☐ Poor ☐ Eats too fast

Please list any food dislikes:

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Applicant ___________________________________ **Caregiver**__________________________________

Applicant Assessment (cont.)

Toileting

Bowel and Bladder:

Incontinence of Bladder: ☐ Yes ☐ No ☐ Nighttime Only

Incontinence of Bowel: ☐ Yes ☐ No ☐ Nighttime Only

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

Help Required: ☐ None ☐ Reminders ☐ Physical Assistance ☐ Positioning ☐ Supervision ☐ Hygiene ☐ Diapers

Any other toileting concerns? If so, please explain:

Dressing

Help Required:

☐ None ☐ Lay out clothing ☐ Supervise only ☐ Verbal cuing ☐ Physical Assistance
☐ Cooperative ☐ Resistant

Behavior (Please check ALL that apply)

Communication

☐ Difficulty communicating wants and needs
☐ Difficulty completing sentences
☐ Sentences do not make sense
☐ Difficulty naming people
☐ Difficulty expressing self Please explain: ____
☐ Has difficulty concentrating on a task or activity
☐ Takes little or no interest in activities and will not start them by self
☐ Often asks the same questions over and over again
☐ Loses or misplaces objects
☐ Has difficulty following simple directions
☐ Hoards objects
☐ Wanders away from home: # of times: __________ ☐ Wanderer's Bracelet ☐ Medic Alert Bracelet
☐ 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 anxious When: ______________________________
☐ Becomes agitated When: ______________________________
☐ Becomes stubborn or uncooperative When: ______________________________
☐ Engages in embarrassing or socially inappropriate behavior How: ______________________________
☐ Talks to people he/she doesn't know
☐ Denies or seems unaware that anything is wrong
☐ 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

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Applicant ______________________ **Caregiver**______________________

Applicant Assessment (cont)

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
Does or has any other family member had AD? ☐ 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 ______________

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	☐	☐	Drawing/Painting	☐	☐	Cooking/Baking	☐	☐
Gardening	☐	☐	Walking	☐	☐	Looking at Magazines	☐	☐
Handyman, Mr. Fixit	☐	☐	Dancing	☐	☐	Traveling	☐	☐
Children	☐	☐	Grandchildren	☐	☐	Other	☐	☐

How does the applicant currently spend his/her day?

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

General Applicant Data – <u>Optional</u> – For Statistical Purposes Only

Gender: ☐ Male ☐ Female Place of Birth: ______________ (City/State) Ethnic Background: ______________

Year emigrated to US: ______________ Primary Language Spoken: ☐ English ☐ Other: ______________

Nickname: ______________ Likes To Be Called: ______________ Religion: ______________

Age at retirement: ______________ How did the applicant adjust to retirement? ______________

Is the applicant a veteran? ☐ Yes ☐ No Education: ☐ 8th grade ☐ High School ☐ College ☐ Other: __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed If widowed, how did he/she adjust? __________

What have we not asked you that you think we need to know?

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Current Medications

Please list ALL medications being taken.
List both PRESCRIPTION and NON-PRESCRIPTION, over the counter drugs, herbal and natural supplements, **whether they will be taken at the center or not.**
In an emergency, EMT's will ask about ALL medications being taken.

APPLICANT NAME: ______________________________ **DATE:** ___________

Date	Medication Name	Dose	Frequency	Reason for Taking	Will take at center
(Example) 10/10/2000	*(Example)* Risperdal	*(Example)* 0.5 mg	*(Example)* 1 tab each day	*(Example)* Anxiety	*(Example)* Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

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S:\Participants\Pre Enrollment\Current Medications Application 08

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These items will be discussed during the pre-enrollment visit, and may be signed at that time. Signatures # 1, 2 and 3 are required for enrollment.

FINANCIAL RESPONSIBILITY (REQUIRED)

I, (please print) ____ understand that I am responsible for all
Caregiver/Responsible Party
fees and charges incurred by (please print) ____ at Alzheimer's Day
Participant
Services of Memphis, Inc.

Sign Here: **# 1 Signature** **Date**

______________________________ ____________________

Billing Address if different than caregiver's address:

____

City/State/Zip

____

AUTHORIZATION FOR EMERGENCY CARE (REQUIRED)

I understand that Alzheimer's Day Services is a social agency and that no medical services are available at Alzheimer's Day Services. I hereby authorize Alzheimer's Day Services of Memphis, Inc. 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 ADS' 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 Alzheimer's Day Services of Memphis, Inc. (ADS) harmless against all losses, damages, accidents or injuries to person or property of any participant or family member, guest, invitee or servant of the participant or caregiver caused by or resulting from or in connection with his/her/their use or occupancy of the ADS premises or things in or about the ADS premises including travel to or from ADS.

Sign Here: **# 3 Signature** **Date**

______________________________ ____________________
Caregiver/Responsible Party

PHOTO/MEDIA/ARTWORK/ RELEASE (OPTIONAL)

I give to Alzheimer's Day Services unlimited permission to use, publish and republish in the furtherance of it's work, reproductions of my likeness by photographic or electronic media means (such as television, 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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Physician's Statement Form

Fax return to: (901) 370-5642

DATE: ___________________________

TO: _____________________________

MD Fax: __________________________

Your Patient's (Name):____

(Address):____

is making application to attend the Alzheimer's Adult Day Services program. Please complete the following and return to Alzheimer's Day Services of Memphis , 3185 Hickory Hill Road, Memphis, TN 38115-2533 or FAX to (901) 370-5642.

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:

Alzheimer's Day Services of Memphis, Inc.
(901) 372-4585

Location at:
4585 Raleigh LaGrange
Memphis, TN 38128-6413

Mailing Address
3185 Hickory Hill Road
Memphis, TN 3815-2533

Location at:
3185 Hickory Hill
Memphis, TN 38115-2533

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 or Responsible Party)

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