CARINGPLACE OF THE SHOALS

216 Marengo Street, Suite I
Florence, AL 35630
(256) 335-5245

Applicant Information

Full Legal Name: _____ Preferred Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

*Social Security Number: _____- _____ - _____ Medicare Number: _____
*The Social Security Number will be released only to medical personnel in an emergency.

Birth Date: _____/_____/_____ Age: _____ Height: _____ Weight: _____

Gender: [ ] Male [ ] Female Primary Language: [ ] English [ ] Other _____

Education: [ ] 8th Grade [ ] High School [ ] College [ ] Other _____

Previous Occupation: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Responsible Party/Primary Caregiver

Name: _____ Relationship: _____

Address: _____

Phone: _____ Secondary Phone: _____

Place of Work: _____ Work Phone: _____

E-mail address: _____

Are you the Legal Guardian [ ] Yes [ ] No If no, who is Legal Guardian? _____

Phone Number: _____ Address: _____

_____

What are applicant's living arrangements?
[ ] Lives alone [ ] With Spouse [ ] With relative [ ] Hired caregiver [ ] Other _____

Family goals for Day Services: [ ] Socialization [ ] Stimulation [ ] Family Respite [ ] Supervision
[ ] Other _____

Preferred days for Applicant to attend CaringPlace of the Shoals:
[ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday

How was the Applicant/Caregiver referred to this program? _____

Would you like your bill to be mailed to you? [ ] Yes [ ] No, I'll get it at the Center
Bill to: Name _____
Street Address or Box Number _____
City/State/Zip _____

Medical Information and Hospital Preferences

Primary Physician: _____ Specialty: _____
Phone Number: _____ Preferred Hospital: _____

Will the Applicant require assistance with medication while at the Center? [ ] Yes [ ] No

Has Family completed: [ ] Durable Power of Attorney [ ] Do Not Resuscitate or A.N.D. Order

Legal Guardian: _____
Please provide documentation of legal guardianship and any of the above forms (DNR/A.N.D)

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

Name	Address	Phones: Home, Cell, Work	Relationship to Applicant
Legal Guardian:			

Applicant Assessment Data

Diagnosis of Memory Impairment:
Date of diagnosis of Dementia _____ Applicant aware of the diagnosis? [ ] Yes [ ] No
Specific diagnosis: _____

Hearing Impairment:
Right Ear: [ ] No Loss [ ] Some/Complete [ ] Hearing aid [ ] Refuses to wear
Left Ear: [ ] No Loss [ ] Some/Complete [ ] Hearing aid [ ] Refuses to wear

Visual Impairment:
Right Eye: [ ] Yes [ ] No Left Eye: [ ] Yes [ ] No
Glasses: [ ] Yes [ ] No Doesn't wear them because _____
Dentures: [ ] Yes [ ] No [ ] Full [ ] Partial [ ] No teeth [ ] Removable bridge

Walking:
Any recent falls: [ ] Yes [ ] No If yes, when? _____
How many falls have occurred in the last six months _____
Help Needed: [ ] None [ ] Cane [ ] Crutches [ ] Walker [ ] Wheelchair [ ] One to one

Eating:
[ ] With no help [ ] With assistance [ ] Other eating considerations _____
_____

Swallowing:
Problems swallowing/choking: [ ] Yes [ ] No
List any particular foods which cause choking: _____

Diet:
[ ] Regular [ ] No additional sugar [ ] No additional salt [ ] Other restrictions _____
_____

Appetite:
[ ] Good [ ] Poor Current weight_____ [ ] Weight Gained _____ [ ] Weight Lost_____
[ ] Neither gained or lost If weight gained or lost, how much in the last 30 days _____ 60 days _____

Tobacco:
[ ] Smoke [ ] Chew [ ] Dip If so, how much?_____

Toileting:
Incontinent of the bladder: [ ] Yes [ ] No [ ] Night time only
Incontinent of the bowel: [ ] Yes [ ] No [ ] Night time only
Products used in daytime: [ ] None [ ] Liners [ ] Pads [ ] Adult diapers
Help required: [ ] None [ ] Reminders [ ] Physical Assistance
[ ] Positioning [ ] Supervision [ ] Diaper Change

Dressing:
[ ] No help required [ ] Verbal cueing [ ] Physical Assistance

Behavior (please check all that apply):
[ ] Difficulty communicating wants and needs
[ ] Difficulty concentrating on a task or activity
[ ] Has wandered away _____ times [ ] Wanderer's bracelet [ ] Medic Alert Bracelet
[ ] Cannot be left alone, must be supervised
[ ] Becomes verbally abusive if _____
[ ] Becomes combative if _____
[ ] Becomes anxious if_____
[ ] Becomes resistant if _____
[ ] Upset by certain words or subjects – please explain _____
[ ] Talks to persons not known
[ ] Sees or hears things other people do not
[ ] Exhibits paranoia – how? _____
[ ] Behaves dangerously – how? _____

[ ] Other behaviors not listed above that we should know about, please explain:

_____

_____

If applicant becomes anxious, what coping strategies work best for calming their anxiety? _____

_____

Personality:

Current pattern of relating to others: [ ] Outgoing [ ] Social [ ] Quiet [ ] Solitary

Does the applicant read? [ ] No [ ] Yes If yes, what? _____

Does the applicant write? [ ] No [ ] Yes

Has the applicant ever used a computer? [ ] No [ ] Yes

How did the applicant spend leisure time prior to dementia?

How does the applicant spend time during the day?

What is special about the applicant that we should know?

Family Long Term Plan of Care:

Do you need information about Long Term Care? [ ] Yes [ ] Not now

Do you currently have Long Term Care Insurance? [ ] Yes [ ] No If yes, please give name of insurance company

_____

Is applicant currently on a nursing home waiting list? [ ] Yes [ ] No

If so, where? _____

Name of person completing this form_____

_____ _____

Responsible Party Signature Date

_____ _____

Staff Signature Date