

Sojourn Adult Day Services LLC

Sojourn Suites LLC

8/15/2009

Admission Application

Referral Source _____

Taken by _____

Date _____

Participant Information

Participant Name _____ Telephone _____ Sex (M-F_) _____

Address _____

Current living arrangements _____

DOB _____ Social Security # _____

Marital Status: _____ Veteran (Y/N) _____ Religious Preference _____

Date Service starts _____ Date Service ended _____

Medical Information

Diagnosis _____

Reason for initiation of services: _____

Diabetic: Y or N _____ If yes, sliding scale ? _____

Allergies _____ Special Dietary needs: _____

TB status if known _____

Does participant need assistance in taking medications ? Y/N _____

Health Insurance information

Insurance Company _____ Private Pay Y/N _____

Plan name and plan number _____ Card number _____
(Medica, HP, Ucare, Other) (Provide copy of insurance card)

Medicare number _____ (Provide copy of Medicare card)

Is participant on Medical Asssistance Y/N _____ MA case number _____

Recipient ID# _____ Team # _____

MA expiration date _____

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Physician/Health Care Information

Primary Physician's name _____ Physician's phone _____
Fax number _____

Physician's address _____ Speciality _____

Second Physician's name _____ Physician's phone _____
Fax number _____

Physician's address _____ Speciality _____

Psychiatrist name _____ Psychiatrist phone _____
Fax number _____

Psychiatrist address _____

Hospital preference
Address _____
Phone _____ Fax _____

Current Pharmacy
Address _____
Phone _____
Fax _____

Heath care directive Y/N _____ DNR form Y/N _____ (Provide copies of both)

Funeral Home
Address _____
Phone _____
Fax _____

Dentist name and phone # _____

Optometrist name and phone # _____

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Caregiver Information

Primary Caregiver:

Name	Relationship	_____
_____	Emergency contact Y/N	_____
Address	Billing Party Y/N	_____
_____	State	_____
City	Zip	_____
_____	Work phone	_____
Home phone	Cell	_____
_____	Fax	_____
Email address:	_____	_____

Secondary Caregiver

Name	Relationship	_____
_____	Emergency contact Y/N	_____
Address	Billing Party Y/N	_____
_____	State	_____
City	Zip	_____
_____	Work phone	_____
Home phone	Cell	_____
_____	_____	_____
Email address:	_____	_____

Power of Attorney

Name	Relationship	_____
_____	_____	_____
Address	_____	_____
_____	State	_____
City	Zip	_____
_____	Work phone	_____
Home phone	Cell	_____
_____	_____	_____
Email address:	_____	_____

County Case Worker

Name	Agency	_____
_____	_____	_____
Address	_____	_____
_____	State	_____
City	Zip	_____
_____	Work phone	_____
Work phone	Cell	_____
_____	_____	_____
Email address:	_____	_____

Agencies Presently Providing Care:

Agency	Service	_____
_____	Telephone	_____
Contact Name	_____	_____
_____	Service	_____
Agency	_____	_____
Contact Name	Telephone	_____
_____	_____	_____

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Needs Assessment

Does participant need to receive physical, speech or occupational therapy and if so, what service ?

Does your relative need assistance with toileting (Y/N)? _____

If so, how can we assist ? _____

Does your relative have any problems/impairments in any of the following areas ? Check

Alcohol	_____	diabetes	_____	Leg cramps	_____
Alertness	_____	Dizziness	_____	Mental condition	_____
Allergies	_____	Drugs	_____	Paralysis	_____
Alzheimer's	_____	Eyesight	_____	Parkinson's	_____
Ambulation	_____	Fainting	_____	Pulmonary disease	_____
Arthritis	_____	Foot care	_____	Shortness of breath	_____
Cataracts	_____	Glaucoma	_____	Seizures	_____
Chest Pain	_____	Headaches	_____	Skin problems	_____
Choking	_____	Hearing	_____	Sleeping	_____
Communication	_____	Hernia	_____	Stomach complaints	_____
Confusion	_____	High blood pressure	_____	Swallowing	_____
Coughing	_____	Incontinence of bladder	_____	Swollen ankles	_____
Dental	_____	Incontinence of bowels	_____	Wandering	_____
Dentures	_____	Infections	_____		

Please describe any details regarding above checked concerns: _____

Functional Status:

Mobility/Ambulation: Please X any of the following:

Walks alone	_____	Walks with assistance	_____
Cane	_____	Walker	_____
		Wheelchair	_____

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Psycho-Social Status

If you are the caregiver, please describe your support and any difficulties in providing care to your relative _____

Please describe any behavioral problems your relative has and the best method to approach the situation. (Anxiety, hostility, suspiciousness, memory loss, disorientation, depression, suicide, etc) _____

Participants major life changes: (death of a loved one, changed residence, major illness, etc) _____

Participants level of education _____

Language spoken if different than English _____

Participant carries Purse _____ ID _____ Money _____ Keys _____

May participant have photograph taken and possibly published ?

Yes _____ No _____

We are required to call 911 for medical services in the event of an emergency.

Please advise if you have any additional information necessary in the treatment of your relative

I have executed an advance Health Care Directive and have provided a copy to this agency

I have executed a DNR (do not resuscitate) form and have provided a copy to this agency

I have not executed an advance Health Care Directive

Signature of person filling out form _____

Date _____ Phone Number _____

This form replaces forms 04-102.02 and 04-101.03 in the Class F manual

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Social History

Birthplace _____ Childhood town _____

Past occupations _____

Company names _____

Religious preference _____

Active in church now _____ Name of church _____

Current marital status _____ Past _____

Pets _____ What kind; Names _____

Family History

Childhood family members names _____ Relationship _____

Present family member names _____ Age _____ Relationship _____

Extended family names (in laws-grandchildren) _____ Location _____

Living friends names _____ Age _____ Location _____

Any other information you would like us to know about you ?

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Leisure Interest Inventory

COGNITIVE ACTIVITIES

Cards

Poker _____ Yahtzee _____
500 _____ Scrabble _____
Uno _____ Chess _____
Solitaire _____ Checkers _____
Crazy 8's _____ Boggle _____

Table Games

Reading _____
Crossword Puzzles _____
Word Find _____
Newspaper _____
Trivia _____

Other

Wheel Of Fortune _____
Monopoly _____
Book Club _____
Parchese _____
Other _____

SPIRITUAL ACTIVITIES

Worship Service _____
Hymn Sing _____

Meditation _____
Devotions _____

Prayer Group _____
Bible Study _____

PHYSICAL ACTIVITIES

Strength Training _____
Seated Exercise _____
Seated Yoga _____
Richard Simmons _____

Tae Boe _____
Fishing _____
Golf _____

Bowling _____
Pool/Billiards _____
Walking _____
Horseshoes _____

Any other sports you'd like to tell us about _____

MUSICAL ACTIVITIES

Singing _____ Instruments _____
Favorite Genre _____ Drumming Group _____
Concerts (type) _____
Choir _____ Tone Chimes _____

Anything else about music you'd like us to know _____

CREATIVE ACTIVITIES

Drawing _____ Paint _____ (type) _____
Sewing _____ Crochet/Knitting _____
Acting _____ Journaling _____
Woodworking _____ Ceramics _____ Dance _____
Latch hook _____ Clay sculpture _____

SOCIAL ACTIVITIES

Intergenerational Programs (Is any particular age group unenjoyable? _____)

Parties _____ Veteran Groups _____ MN Landscape Arb. _____
Dances _____ Red hat ladies _____ Pontoon boat _____
Special Entertainment _____ Large Group Games _____ Art Museums _____
Bingo _____ Charades _____ Sightseeing _____
Pictionary _____ Family Feud _____ Random outings _____