

The Continuum ReGenerations Admission Forms Packet

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Instructions

1. Please print out the forms and fill them out completely. Print legibly.
2. Please feel free to call for assistance. Ask for Denise Hund and she will be happy to answer your questions.
3. We ask that a family member or close friend assist the client in completing this form. This information is extremely helpful in providing the most effective program. In addition, it will help us provide activities that are of interest to the ReGenerations participant. Some of the questions may not pertain to your family member, if this is the case please write "DNA" (does not apply) in the space.
5. **After completing the forms, you may fax, mail, or bring them to the address below.**
6. Thanks for your cooperation. This information will be kept confidential.

The Continuum
3700 Grant Drive, Suite A
Reno, NV 89509
775-829-4700
775-829-4710 (fax)
medrecords@thecontinuum-reno.com
sched@thecontinuum-reno.com



The Continuum ReGenerations

NEW CLIENT INFORMATION SHEET (PLEASE PRINT)

CLIENT

CLIENT NAME _____
LAST FIRST MI

PHYSICAL ADDRESS _____
STREET CITY STATE ZIP

BILLING ADDRESS

(IN CARE OF) _____
STREET CITY STATE ZIP

EMAIL ADDRESS _____

Please indicate if you want all correspondence from The Continuum sent in a sealed envelope marked "Confidential" Yes () No ()

PHONE NUMBER () _____ () _____ () _____
HOME CELLULAR OTHER

Please indicate the telephone number where you want to receive calls about your appointments, billing questions, or other healthcare questions _____. Please note that we will use this number to leave messages regarding the above if there is no answer.

I am fully aware that a cell phone is not a secure and private line.

DATE OF BIRTH ____/____/____ SSN ____-____-____ MALE () FEMALE ()
PLEASE USE 4-DIGIT YEAR PATIENT SOCIAL SECURITY NUMBER

PRIMARY OCCUPATION _____ RACE _____
(PRIOR TO RETIREMENT)

RELIGION _____ MILITARY AFFILIATION _____

PHYSICIAN/HOSPITAL

PRIMARY CARE PHYSICIAN _____
NAME PHONE

PRIMARY DIAGNOSIS _____

HOSPITAL PREFERENCE _____

TRANSPORTATION to CONTINUUM _____
NAME PHONE

Please list the family members or significant others, if any, whom we may inform about your medical condition.

ONLY IN AN EMERGENCY:

NAME _____ Phone () _____ - _____
NAME _____ Phone () _____ - _____

ADDRESS of NEXT OF KIN OR GUARDIAN NOT IN RESIDENCE

Admission Criteria for ReGenerations

Pursuant to Title VI of the Civil Rights Act of 1961, ReGenerations Program is nondiscriminatory. Religion, race, national origin, alienage, handicap, age or sex will not be considered in client admission process or treatment following admission.

Admission Criteria for appropriate ReGenerations placement:

- ◆ Client must have a physical examination conducted by a physician, physician's assistant or nurse practitioner, within six months prior to admission into the ReGenerations program. The updated physical along with a complete medical history and any dietary restrictions must be provided before the first attendance day.
- ◆ Client or primary caregiver shall designate a physician to be called in case of an emergency. The ReGenerations staff shall have the right to seek emergency treatment from paramedics should the need arise and the designated physician is unavailable.
- ◆ Client or primary caregiver is required to update the ReGenerations Coordinator of any changes in medications or physician's orders.
- ◆ Client must have proper ID with them at all times.
- ◆ Client should be continent of bowel and bladder and require a minimum of staff assistance with toileting. Clients requiring extra assistance will be taken on a case-by-case basis. Scheduled bowel and bladder programs are arranged for clients willing to participate.
- ◆ Clients should not be considered dangerous to self or others. Clients engaging in disruptive behavior are subject to dismissal from the program.
- ◆ Client must be able to communicate his or her needs to ReGenerations staff either verbally, written, or through gestures.
- ◆ Client must be able to participate in the daily program with an appropriate understanding of why they are a participant and what their daily regime entails.
- ◆ Client must not require any form of restraint or sedative unless ordered by a physician.
- ◆ Client or primary caregiver is responsible for arranging transportation to and from the ReGenerations facility.
- ◆ Client or caregiver is responsible for providing proper daily dosage of medication taken while in the ReGenerations program. Client will self-administer own medication. The ReGenerations Coordinator will have a secure area for client's medication.
- ◆ Client or caregiver is responsible for informing the ReGeneration staff if they are unable to attend on a scheduled day. Clients frequently canceling without prior notification are subject to termination from the program. There is a \$10.00 charge for all no call, no show's and for cancellations not made prior to 9 am on any scheduled day.
- ◆ Clients are served a noon meal, meeting 1/3 of the RDA requirements. Any concerns regarding our noon meal service should be reported to the ReGenerations director. ReGenerations clients remaining in the facility longer than 6 hours will be provided with extra nourishment. Depending on dietary restrictions, the ReGenerations staff will also provide extra nourishment as required or requested by a ReGenerations client.

Standard Admission Waiver

The management of this program has agreed to exercise such responsible care toward this person as his or her own condition may require, however, the ReGenerations program is in no sense an insurer of his or her safety or welfare and assumes no liability as such.

The management of the ReGenerations program will not be responsible for any valuables or money left in the possession of participants while he or she is active in the program.

Client

Date

Responsible Party

Date

Denise Hund, ReGenerations Coordinator

Date

ReGeneration's Financial Agreement

I, _____ hereby agree to the following financial terms and arrangements as they pertain to me while enrolled in the Adult Day Program.

The fees are as follows:

\$63.00 Full Day w/lunch*

\$45.00 Half Day w/lunch**

\$40.00 Half Day w/out lunch*

*The half day program hours are: 7:30 am – 1:00 pm **or** 12:00 pm – 5:00 pm.

*A \$75.00 registration and processing fee will be paid upon completion of a pre-admission interview.

I understand that the Adult Day program is billed on a day to day basis, therefore I will be charged according to each day of attendance. I agree to pay The Continuum / ReGeneration's Adult Day Center upon receipt of their statement. The Continuum will mail statements for the previous month by the fifth day of each month. I understand that the financial responsibility is mine and that The Continuum/ReGeneration's Adult Day Center will not bill an insurance company for the services provided. I also understand that if I am not going to attend ReGenerations on a scheduled day then I must call by 9 am that morning or I will be charged a \$10.00 no call/no show fee.

(Print Name of Participant)

Date

(Signature of Participant or Guardian)

Date

Adult Day Representative

Date

**The Continuum
ReGenerations Program
Privacy Disclosure**

The Continuum offers a variety of activities throughout the month for you and/or your family member to enjoy. Due to the recent implementation of the Health Insurance Portability and Accountability Act (HIPPA) we want to inform you that many people from the community will be in ReGenerations for your enjoyment and entertainment. We provide each client with a calendar at the beginning of each month so that you may be prepared for each activity.

It has become necessary that you sign a Privacy Disclosure acknowledging your awareness of our activities.

I am aware that The Continuum arranges many activities that may involve different members of our community and I am aware that they have signed confidentiality statements disclosing that they may not discuss or repeat any patient or personal information they may hear while visiting The Continuum.

I wish to be notified whenever a scheduled or non-scheduled member of our community is to attend ReGenerations whether to perform or help with a scheduled activity.

Phone Number: _____.

Best time to call: _____.

Client Name: _____

Client/Guardian Signature: _____

**The Continuum
Consent for Photography, Audio-Taping, and/or
Video-Taping and Release**

I authorize The Continuum to photograph, video and/or audio tape _____, which **may** be used for clinical purposes.

I do not authorize The Continuum to photograph, video and/or audio tape _____, for clinical purposes.

I authorize The Continuum to photograph, video and/or audio tape _____, which **may** be used for marketing purposes.

I do not authorize The Continuum to photograph, video and/or audio tape _____, for marketing purposes.

Client Name

Signature of Client / Parent / Guardian Date

Social History

We ask that a family member or close friend help complete this form. This information is extremely helpful in providing the most effective program. In addition, it will help us provide activities that are of interest to the ReGenerations participant. Some of the questions may not pertain to your family member, if this is the case please write "DNA" (does not apply) in the space.

General Information:

Married _____ Date _____ Single _____ Divorced _____
Widowed _____ Date _____
Name of Spouse _____
Parent's names _____
Are parents living? _____ If so, where _____
Place of Birth _____
State/Countries lived in _____
Travel Experience _____

School and Work History

Schools attended/Grade School, High School _____
College _____

Degrees _____
Favorite subjects in school _____
Work History _____ Date of Retirement _____
Attitude toward work (like/dislike) _____
Does client speak more than one language? _____
Does client do any writing? _____ longhand _____ printing _____ computer _____
Does client read? _____ books _____ kinds of books _____ magazines _____ newspaper _____

Personal Interests

Hobbies/interests _____

Recreation: outdoors _____ indoors _____
Play any musical instruments: _____
Other skills/talents (art, typing, sports, singing, etc.) _____

Club/Organizations/Church (membership) _____

Family Goals and Information

Family's impression of major strengths _____
What are the goals of the client? _____
If applicable, what type of positive reinforcement may motivate client? _____
Any topics of discussion to be avoided? _____
Any cultural sensitive areas we should know about? _____

Reaction of friends and relatives since onset _____

Client' sons, daughters, and grandchildren

Name	Nickname	Relationship	Age	City/State

Other close relatives

Name	Nickname	Relationship	Age	City/State

Close friends/associates (neighbors, church, co-workers, etc.)

Name	Nickname	Relationship	Age	City/State

Medical Information

Primary Diagnosis_____

Approximate date of onset_____

Describe any major illness or accident in addition to primary diagnosis_____

Since this onset_____

Personality characteristics prior to onset (outgoing, shy, social etc.)_____

Personality characteristics since onset_____

Is client continent? Yes/No _____ Daytime _____ Nighttime _____

Does client wear glasses? Yes/No _____ reading _____ driving _____ all the time _____

Does client have hearing loss? Yes/No _____ right ear _____ left ear _____ both ears _____
hearing aid? _____

Does client wear dentures? Yes/No _____ partial _____ complete _____

Food preferences _____

Food Allergies _____

Diet restrictions _____

Other allergies _____

Medications

Name of med taken for	# taken	times per day	date begun
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**** Please Notify if any changes.**

Screening Questions for Adult Day Club Members

1. Is your family member having difficulty completing any of the following activities of daily living? (Not applicable, N/A, if he/she does not complete this activity now, and/or will not in the future)

- | | | | |
|-------------------------|--------|--------|----------|
| ◆ DRESSING | Y_____ | N_____ | N/A_____ |
| ◆ BATHING | Y_____ | N_____ | N/A_____ |
| ◆ TOILETING | Y_____ | N_____ | N/A_____ |
| ◆ GROOMING | Y_____ | N_____ | N/A_____ |
| ◆ FEEDING | Y_____ | N_____ | N/A_____ |
| ◆ MEAL PREPARATION | Y_____ | N_____ | N/A_____ |
| ◆ MEDICATION MANAGEMENT | Y_____ | N_____ | N/A_____ |
| ◆ MONEY MANAGEMENT | Y_____ | N_____ | N/A_____ |

2. Do you feel your family member would benefit from any of the following modifications or adaptations?

- | | | |
|--------------------------------|--------|--------|
| ◆ GRAB BARS in or near bathtub | Y_____ | N_____ |
| ◆ GRAB BARS near the toilet | Y_____ | N_____ |
| ◆ SHOWER CHAIR or TUB BENCH | Y_____ | N_____ |
| ◆ RAISED TOILET SEAT | Y_____ | N_____ |
| ◆ HAND-HELD SHOWER | Y_____ | N_____ |
| ◆ RAMP | Y_____ | N_____ |
| ◆ RAILINGS | Y_____ | N_____ |
| ◆ BED RAIL | Y_____ | N_____ |

3. Are you concerned about any of the following areas?

- | | | | |
|---------------------|--------|--------|----------|
| ◆ SWALLOWING | Y_____ | N_____ | N/A_____ |
| ◆ CLARITY OF SPEECH | Y_____ | N_____ | N/A_____ |
| ◆ COMMUNICATION | Y_____ | N_____ | N/A_____ |
| ◆ VOICE (too soft) | Y_____ | N_____ | N/A_____ |

