Respite Day Care Guest Assessment

DNR? Yes ☐ | No ☐
[form MUST be on file]

Today's Date: ________

Next Update? ________

Name ________________________________

DOB ________________ **Age at Intake** ________________

Race ________________ **Ethnicity** ________________

Address ________________________________

City ________________ **AZ Zip** ________________

Phone Number (______) ________________

Mobile (______) ________________

Caregiver Name ________________________________

Relationship ________________________________

Mobile Number (______) ________________ **Secondary** (______) ________________

Emergency Contact Name ________________ **Tel** (______) ________________

Primary Doctor ________________ **Tel** (______) ________________

Health Insurance Carrier ________________ **ID#** ________________

Medical and Health Condition

Medical diagnosis (if any): ________________________________

Special Diet and /or Nutritional Needs ________________________________

Medical or Food Allergies: None: ____ Yes: ____

(Specify) ________________________________

Referred by (i.e. self, friends, family, etc.): ________________________________

Goals: ________________________________

____

Please mark any that apply:

Health Issues
Hearing ______
Uses hearing aid ______
Speech ______
Vision ______
Swallowing ______
Breathing ______
Oxygen ______
Mobility ______
Other ____________

Toileting and incontinence
Self-toilets ______
Wears pads ______
Tab adult diaper ______
Fitted adult brief ______
Incontinent bladder ______
Incontinent bowel ______
Catheter ______
Ostomy Care ______
Other ____________

Cognition
Dementia ______
Oriented to time and place?
Yes ______ No ______
Alzheimer's ______
Wandering? ______
Aggression? ______
Other ____________
____
____

1 person transfer _____

2 person transfer _____

Hoyer lift _____

Medications

Self-Administers _____

Needs Reminders _____

Times of day medications are taken

____

- *Please provide a list of current, dated medication in case of emergency.* ☐

Care Group:

Supervisory ☐

Personal Care ☐

Directed Care/Dementia ☐

Staff initials ____________

NOTES:

If caregiver has a different address, please note that here: