

**ADULT DAY HEALTH CENTER
ADMISSION SUMMARY**

Client: _____ Client# _____
Address: _____ Phone# _____

Lives Alone: _____ Lives w/family: _____ Other: _____

Responsible Party: _____ Other: _____

Address: _____ Phone#: _____

Payment type: Private _____ Medicaid (HMO) Amerigroup _____ Evercare _____

Medicare _____ Respite _____ Other _____

Race: _____ Religion: _____

Admission Date: _____ / _____ / _____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Date of Birth: _____ / _____ / _____ Social Security: _____

Medicare#: _____ Medicaid#: _____

Medical Diagnosis: Primary: _____

Secondary: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone#: _____

Emergency Contact: _____ Relationship _____

Address: _____ Phone#: _____

Hospital Preference: _____

Primary Physician: _____ Phone#: _____

Address: _____

Podiatrist: _____

Does this client have a legal guardian? Yes _____ No _____

If yes, name of guardian: _____

Address: _____ Phone# _____

Referral Source: _____

Transportation Required: Yes _____ No _____ Zone _____

Photo Release: Yes _____ No _____

TO BE COMPLETED UPON TRANSFER TO HEALTH CARE FACILITY

Current Medications: _____

Reason for Transfer: _____

Comments: _____

Date of Transfer: _____ / _____ / _____ Time: _____ Facility: _____

Signature of Nurse Completing
Transfer Information: _____