Adult Day Services
4601 N. Choctaw Road
Choctaw, Oklahoma 73020
Phone: (405) 390-4400 Fax: (405)390-6637

Admissions Packet

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E.O.C. Adult Day Services
ADMISSION PARTICIPANT RECORDS CHECKLIST

Participant: ____

Admit Date: ________________________

			Funding Approved
Advantage	DHS	Private Pay	VA

	Initials	Date
Part I – Items needed prior to admission		
Pgs. 1-2 Admission Requirements		
Pg. 3 Auth. for Release of Medical Information		
Pg. 4 Confidentiality Guidelines		
Pg. 5 Contract for Services		
Pg. 6 Emergency Information		
Pg. 7 General Release of Liability		
Insurance Verification Cards (Copy of Medicare, Medicaid, & private insurances)		
Pg. 8 Medication Administration Procedures		
Pgs. 9-11 Medical History Form		
Pgs. 12-14 Notice of Privacy Practices (HIPAA) (Participant keeps pgs. 14 & 15)		
Pgs. 15-16 Physical Examination		
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Part II – Items needed during nursing assessment		
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Service Plan		
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Administrative Review	Date
Program Nurse (or designated signature)	

(Revised 1/03/11)

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Admission Requirements

- EOC Adult Day Services will not enroll any person whose needs exceed the capability of the program. Participants whose needs cannot realistically be met by the planned program will not be enrolled. EOC Adult Day Services does not provide skilled nursing services.

- Acceptance into the EOC Adult Day Services Program is provisional and there will be a 10 day trial period to see if the program is appropriate for ones needs. If participant exhibits behavior that interferes with the operation of the EOC Adult Day Services, I understand he/she will be discharged from the program.

- Admission will not be determined by race, color, religion, gender, national origin, marital status, and will not affect the decision to admit for services.

- No Alcohol/Tobacco/Drug use or paraphernalia on the premises of EOC Adult Day Services or on the EOC Technology campus.

The EOC Adult Day Services program uses the following criteria as admission guidelines for admittance into the program:

1. Evidence that participant has a medical, physical or psychosocial condition that requires another level of care which cannot be met by our facility.
2. Participant must be free of any infectious communicable disease, i.e., HIV, TB, Hepatitis or MRSA (Staph Infection).
3. Participant must be able to assist with transfers and has demonstrated adequate gait and safety measures.
4. Participant must be able to feed self with very little assistance from staff.
5. If participant has had a stroke must be able to swallow small cut up pieces of food without difficulty.
6. Participant must be continent of stool and in control of bowel function.
7. If participant is incontinent of urine, they agree to wear Attends, pads or other effective undergarments.
8. Participant must be able to sit upright for intermittent times at the facility.
9. Participant must be on medication to have seizures maintained and under control.
10. Participant must be able to self administer their own insulin and together with their Physician, have their condition managed while at the EOC Adult Day Center
11. Participant's Vital signs will be stable upon admission and will be managed by a Physician.

12. Participant cannot be physically abusive to others, nor exhibit repeated/uncontrolled verbal abuse, or exhibit any sexually inappropriate behavior or behavior that interferes with the operation of the program.
13. Participant must schedule with the Program Nurse an assessment to evaluate medical needs while at the EOC Adult Day Services.
14. Participant must provide a current "Physical Examination" form that is completed and signed by the Physician.
15. Participant must provide an accurate "Physician Medication Order" form of medications to be given while at the EOC Adult Day Services, along with a medication bottle that reflects the physician's orders. (This order needs to be separate from the original order of medications taken at home and in a separate medication bottle labeled to reflect the order for medications given at the Adult Day Center.).
16. Participant will provide a yearly updated physical from your current physician, updated emergency contact form and an updated authorization for release of medical information.
17. A licensed Dietitian will review the care plan and dietary needs will be addressed, if needed, according to medical diagnosis for the participant while at the EOC Adult Day Services. (Exp: Hypertension – Salt Restriction)
18. If participant becomes in need of Emergency Medical Services, 911 will be called immediately and then family will be notified.*

*** The above admission requirements are written in compliance with State Regulation, Title 310:605-13-2 from the Oklahoma State Department of Health.**

I have read these admission requirements, and to my knowledge, _________________________ (Participant's name) currently meets the admission criteria of the EOC Adult Day Services and will be able to participate in the program.

____ __________________________

Participant/Caregiver/Guardian Date

(Revised 1/03/11)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: ____ SS # _________________________

DOB ____/____/____ Male ____ Female_____

The purpose or need for this disclosure: ____

This authorizes the below named physician, hospital or other organization, agency or person having medical, health, social or economic records, data or information concerning the above identifies participant to furnish such records as may be required on my behalf by the *EOC Senior Adult Day Services (SADS).*

This also authorizes the SADS to furnish medical, health, social or economic records, data, or information concerning the above identified applicant to the below named physician, hospital or other organization, agency, or person having need for such information.

The participant understands that this authorization is needed to provide *EOC Senior Adult Day Services* for coordination of medical, health, social or other related services. It is understood that information thus obtained by *EOC Senior Adult Day Services* will be treated as confidential information.

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but not be limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). These records may also indicate information about usage of or addiction to chemical substances such as alcohol or drugs.

I understand that I may ask questions, consult with anyone and review these records before I sign this form.

The facility, its employees and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Name: ____

Address: ____

Name: ____

Address: ____

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: ____ Date: ______________
(Participant/Spouse/Guardian)

Witness: ____ Date: ______________

(Revised 1/03/11)
(Meets HIPAA Requirements)

Confidentiality Guidelines

1. All participant records will be kept and treated with strict confidentiality.
2. Participant charts will be kept stored in either a locked file cabinet or behind locked doors.
3. All EOC staff will sign confidentiality agreements as an employment requirement.
4. Participant records will be available only to E.O.C. Adult Day Services staff or other authorized persons.
5. The EOC Adult Day Services is a teaching facility and students from several different classes and schools visit our facility regularly. All students are supervised and are required to maintain confidentiality guidelines when reading charts and interacting with participants.
6. Supportive agencies, Students, and Volunteers that have a part in the direct care of the participant must also sign this confidentiality form to have access to the participant's chart and document in the interdisciplinary progress notes when they visit the participant.
7. Any person who is not an employee of E.O.C. Adult Day Services, who reads a participants chart, must sign this confidentiality acknowledgement sheet.
8. The participant, or their representative, must sign authorization for release of information to and from the E.O.C. Adult Day Services, before any information will be released or requested.
9. Participants are not discussed in the presence of other participants or any unauthorized persons.
10. No information concerning individual clients will be displayed in areas accessible to the public without consent.
11. Forms or documents containing participant information will be maintained in the SADS for at least five (5) years following termination of enrollment by the participant and then disposed of appropriately as confidential information.

I have read and accept the E.O.C. Adult Day Services Confidentiality Guidelines.

____ ___________________
Participant/Caregiver/Employee/Volunteer Date

(Revised 1/03/11)
(Meets HIPAA Requirements)

CONTRACT FOR SERVICES

Participant ____ Phone ___________________

Address

____

Person responsible for payment if different than above:

Name ________________________________ Relationship ________ Phone _____________
Address

____

Fee for Services
I am entering into an agreement of participation with the E.O.C. Senior Adult Day Services in Choctaw, OK. I have been informed that the private pay fee for services is *$60 per eight hour day.* An hourly rate of *$7.50* is paid for attendance of less than 6 hours a day. This fee includes the cost of meal service.

Department of Human Services, Veterans Administration, and Advantage Waiver:
Fee for services is determined by the agency. DHS qualifies individuals based on their income. Co-payment amounts are determined by the DHS county office after an application is submitted. Transportation fees are covered by the above agencies.

I understand that the E.O.C. Senior Adult Day Services relies on participant fees to cover the costs of care and services. A bill will be mailed at the beginning of the month for the previous month's services or upon discontinuation of services. Checks should be made out to **E.O.C. Technology Center**. They may be mailed to:

E.O.C. Technology Center
Attn: Senior Adult Day Services
4601 N. Choctaw Rd.
Choctaw, OK 73020

Payments are due by the 15th of each month. A late fee of $10.00 per week will be charged for balances not paid on time. A fee of $20.00 will be applied for returned checks.

Cancelled Meals/Transportation
When you contract with us for services, we secure meals, staff, and transportation, etc., for the participants. The participant or caregiver will be responsible for notifying the SADS before 8:30 a.m. in cases of unscheduled absences (illness, emergencies, etc.). Notification must be made by noon the day prior to a scheduled absence (doctor's appointment, vacation, etc.). Additional charges for meals and transportation not cancelled in a timely manner will be billed as follows: $5.00 for uncancelled meals.

Overtime Fees

The SADS is open 7:30 a.m. - 5:30 p.m. I also understand that an additional fee of $10.00 for any portion of the first fifteen minutes and $5.00 for each additional five minute period thereafter will be charged to participants who depart after the close of the SADS at 5:30 p.m.

The Department of Human services, the Veterans Administration, DDSD and Advantage Waiver ***do not*** *cover delinquent fees, overtime charges, or additional charges for uncancelled meals or transportation.*

____ ________________

Person Responsible for Payment Date

____ ________________

Intake Staff Date

(Revised 1/03/11)

Emergency Contact Information

____

Date

Participants Name:____

Last First M

Participant SSN # _______________________ Participants D.O.B.___________________

Participant Address: ____

Caregiver/Guardian Name & Address: ____

____

Care Giver/Guardian Phone :__________________________

Primary Physician:____

Phone:__________________________

Hospital Preference:____

Medical Diagnosis:____

Allergies:____

In Case Of Emergency Notify:

_______________________________________ _______________ ________________
Name/Relationship Work Phone Home Phone

____
Pager/Cell Phone

____ _______________ ________________
Name/Relationship Work Phone Home Phone

____
Pager/Cell Phone

Medicare :____

IN CASE OF A MEDICAL EMERGENCY: I AUTHORIZE THE SENIOR ADULT DAY SERVICES TO SECURE AND OBTAIN PROPER MEDICAL TREATMENT ON MY BEHALF. IF IN NEED OF AN EMERGENCY VEHICLE, I GIVE THE SADS PERMISSION TO USE MIDWEST CITY HOSPITAL AMBULANCE SERVICE.

PARTICIPANT/CAREGIVER NAME: ____

(Revised 1/03/11)

GENERAL RELEASE OF LIABILITY

I would like to attend the E.O.C. Senior Adult Day Services and participate in the daily program.

My participation is voluntary and I release and agree to hold harmless the E.O.C. Senior Adult Day Services, its employees, volunteers, and agents from any and all liability and responsibility (unless proximately caused by the willful misconduct of any of the above mentioned) for or relating to any illness, accident, or other event which may occur while I am a participant in the program.

_______________________________________ ___________________
Participant Date

_______________________________________ ___________________
Caregiver/Guardian Date

_________________________________ ___________________
Program Staff Date

MEDICATION ADMINISTRATION PROCEDURES

It is understood that the Senior Adult Day Services and its staff will not be responsible for any adverse effects related to the administration of any medication.

I ____, authorize the Senior Adult Day Services to administer any/all medications, to be taken by ___________________________(participant), while attending the SADS, and agree to provide the necessary dosages of these medications.

1. Only a licensed or certified staff member will give any and all medications, including over-the-counter and prescription, during attendance at SADS.

2. Medication brought to the facility must be in a pharmacy bottle with proper pharmacy label or in the original bottle if a non-prescription medication.

3. SADS must have a **physician's medication order** completed by the doctor for all medications to be given at the facility.

4. Medicine bottle label must match the doctor's orders given to facility.

5. If participant is discharged, the medicine must be taken home upon discharge.

6. If participant stops coming to the SADS, we will send one (1) letter home advising the family to pick up all medications. If medication is still on site one (1) week after letter has been mailed, it will be destroyed, per facility policy.

7. If participant should pass away during enrollment at the SADS, all medications will be destroyed, per facility policy.

____ _________________
Participant/Caregiver Date

____ _________________
Program Staff Date

(Revised 1/03/11)

MEDICAL HISTORY FORM

Date: ________________ SSN: ____________________________

Participant____ Sex: _______
Last First Middle

Medical Diagnosis:

1. _________________ 2. __________________ 3.__________________ 4.____________________

Primary Doctor: ____ Phone: _____________________

Address: ____

Secondary Doctor: _______________________________________ Phone: _____________________

Address: ____

Allergies:
To Medications: ____

To Foods: ____

Last seen by physician: ____

Reason for physician visit: ____

Number of doctor visits in the past year? ____

Number of days spent in the hospital in the past year? ___________________________________

Special Diet? ____

Insurance: _____ Medicare _____ Medicaid _____ Insurance Supplement

Participant____ Sex: _______
Last First Middle

Current Medical Status

Weight: ______ Height: ______
Eyesight: ___ Good ___ Fair___ Poor

Glasses: __ Yes __ No ___ Need

Hearing: __ Good __ Fair __ Poor

Hearing Aid: __ Yes (L/R/B) __ No __ Need (L/R/B)

Teeth: ______ Own ______ Edentulous ______Dentures (Upper/ Lower/Need)

Ambulation: ______ Self ______ Cane ______W/C ______ Walker _______Stand-by Assistance

Transfer: ______ Self ______ Assist x1 ______ Assist x2
______ Unable to bear weight

Health Conditions: (Past or Present)

	Yes	No	Comments
Alcohol/Substance Abuse			______________________________
Alzheimer's or other dementia			______________________________
Anemia/bleeding disorders			______________________________
Arthritis/rheumatism			______________________________
Bladder: Continent/Incontinent/ Dribbles			
Bowel: Continent/Incontinent			______________________________
Cancer or leukemia			______________________________
Cataracts			______________________________
Circulation problems			______________________________
Diabetes			______________________________
Difficulty with food, chewing			

Participant____ Sex: _______
Last First Middle

	Yes	No	
Emphysema: COPD, Asthma, Bronchitis			___________________________
Epilepsy/Seizure Disorder			___________________________
Falls/Recent History of			___________________________
Glaucoma			___________________________
Heart trouble, CHF			___________________________
High/low blood pressure			___________________________
Hostile: Withdrawn/Depression			___________________________
Liver disease			___________________________
Mental Retardation			___________________________
Parkinson's disease			___________________________
Skin disorders: pressure sores, Leg ulcers, burns			___________________________
Stomach: intestinal disorders (Diarrhea or constipation)			___________________________
Stroke			___________________________
Thyroid Problems			___________________________
Tuberculosis			___________________________
Urinary tract disorders			___________________________
Wanders			___________________________

Other Illness's, disabilities or injuries: ____

____

Any family history of the above mentioned health conditions?
If yes, please specify which conditions and the relationship to participant:

____

____

Participant____ Sex: ________
Last First Middle

Current medication Dosage Frequency Doctor prescribed?

____

____

____

____

____

____

____

List surgeries: Place Date

____

____

____

____

List other non-surgical hospitalizations:

Reason Place Date

____

____

____

____

Are any of the following in effect?

Power of Attorney: Yes/No
Legal Guardianship: Yes/No
Living Will: Yes/No
DNR: Yes/No

If yes to any of the above legal documents please provide a copy for our records.

Program Nurse: ___________________________________ Date: ____________________

(Revised 1/03/11)

Adult Day Services
4601 N. Choctaw Road
Choctaw, Oklahoma 73020
Phone: (405) 390-4400 Fax: (405)390-6637

Dear Participants and Caregivers,

Enclosed is the E.O.C. Technology Center Senior Adult Day Center Notice of Privacy Practices. This notice of our privacy policy complies with the federally mandated HIPAA regulations (Health Insurance Portability and Accountability Act).

Each caregiver will be asked to provide written acknowledgement that they have received our Notice of Privacy Practices. You will always find our most current privacy policy on display at our Center.

We appreciate you and maintaining your privacy and confidentiality is important to us. If you have received this notice in person, please read the policy and sign. If you have received this notice by mail, please read, sign, and return it to our office as soon as possible.

Sincerely,

Eileen Wilson
Program Director

NOTICE OF PRIVACY PRACTICES
(HIPAA)

You have the right to receive a notice of our privacy practices with respect to your medical and billing information. Your signature here indicates that you have received a copy of our Notice of Privacy Practices.

____ ________________________
Signature of Participant or Legal Representative Date

____ ________________________
E.O.C. Adult Day Services Representative Date

- **Please keep your copy of the HIPPA regulations for your medical records.**

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. E.O.C. TECH SENIOR ADULT DAY CENTER'S DUTIES REGARDING PROTECTED HEALTH INFORMATION.

We are required by federal and state law to maintain the privacy of your protected health information, and in particular your "protected health information," which can be maintained, used, and disclosed in limited ways. "Protected health information" includes most kinds of "individually identifiable protected health information," that is to say, information about (1) your past, present, or future physical or mental health or condition, (2) the health care you receive, and (3) your payment for health care.

The term "use" will mean the sharing protected health information by employees and agents of E.O.C. Tech Senior Adult Day Center, while "disclosure" will mean E.O.C. Tech Senior Adult Day Center providing protected health information to other persons having a need for the information. We reserve the right to change our privacy practices and the corresponding terms of this Notice at any time. This includes, but is not limited to, the right to make changes effective for all protected health information that we maintain, including protected health information we have created or received *before* we make the changes. Before we make a significant change in our privacy practices, we will change this Notice, make it available to you upon request, and post the revised Notice in a prominent location near the entrance to our facility.

You may request a copy of our Notice at any time. For more information about our privacy practices or your rights concerning your protected health information, contact E.O.C. Tech Senior Adult Day Center's Privacy Official using the information at the end of this Notice.

II. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are authorized to use and disclose your protected health information for the following purposes:

For Treatment Purposes. Treatment purposes include the provision, coordination or management of your healthcare. We may, for example, use your protected health information to provide you with health care services, and may disclose your protected health information to your personal physician or another health care provider who is treating you.

For Payment. Payment purposes means our activities to obtain reimbursement for care provided to you. We may, for example, use protected health information in obtaining payment from a third party, such as the Veterans Administration.

For Health Care Operations. Healthcare operations are those functions needed to support our treatment, payment, and business activities in order to provide quality services. For example, your protected health information is used in evaluation the performance of our staff, in our training programs, and in demonstrating to federal and state agencies that we are in compliance with applicable laws.

In Cases of Suspected Abuse, Neglect and Other Injury. We may disclose protected health information to the appropriate governmental agency if we suspect that you have been the victim of abuse, neglect, domestic violence, or other injury.

In Health Oversight Activities. We may disclose your protected health information to federal and state agencies responsible for monitoring our compliance with applicable law and to accreditation entities to ensure that we meet appropriate standards of care.

In Legal Proceedings, Law Enforcement, and As Required By Law. We must disclose your protected health information to the extent it is the subject of a court order, an order from an administrative tribunal, subpoena for documents, discovery request, or some other lawful process with which that we have been served. Moreover, we may communicate your protected health information to law enforcement personnel if necessary to report a crime in an emergency situation.

In Public Health Activities. Under certain circumstances, we may disclose your protected health information to federal and state public health agencies whose mission is to prevent or control disease and injury.

In Situations of Serious and Immediate Threats to Health and Safety. We may disclose your protected health information when, consistent with federal or state law, we reasonably believe disclosure is necessary to prevent or lessen a serious and immediate threat to your health or safety, or that of another individual or the public-at-large.

For Specialized Government Functions. We may disclose your protected health information if needed for certain military and veterans' activities, national security matters, and intelligence activities.

In Situations Involving Military Activity. When appropriate conditions apply, we may use or disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

For Workers' Compensation Purposes. We may disclose your protected health information as authorized to comply with workers' compensation laws and similar programs.
To Personal Representatives. We may disclose your protected health information to certain persons authorized by state law to act on your behalf, including, but not limited to, a guardian, attorney-in-fact, executor or administrator.

To Individuals Involved with Your Care. Under certain circumstances, such as your incapacity, we may disclose protected health information about you to a friend or family member who is involved in your medical care or who pays for the services you receive.

Other Uses and Disclosures. Before we can use or disclose your protected health information for other purposes, we must obtain your written authorization. You or your personal representative can revoke the authorization, but the revocation must be in writing and delivered to us. In addition, the revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

II. OTHER USES AND DISCLOSURES

Health Benefits and Services. We may contact you about health-related benefits and services that may be of interest to you.

Fundraising. We may contact you to raise funds for E.O.C. Tech Senior Adult Day Center.

III. YOUR RIGHTS WITH RESPECT TO PROTECTED HEALTH INFORMATION

If you wish to exercise any of your rights discussed below, contact the Privacy Official identified below:
Access to Protected Health Information. With limited exceptions, you have the right to look at your protected health information. You must submit a written request to the Privacy Official whose name, address, and telephone number are included at the end of this Notice. We can provide you with a request form, or you may mail a request letter to the Privacy Official.

Obtain a Copy, Summary, or Explanation of Your Protected Health Information. You may request in writing a photocopy of your protected health information. We can provide you with a request form, or you may mail a request letter to the Privacy Official. We will charge a reasonable rate (i) per-page and (ii) per-hour for staff time to copy your protected health information. You will also be charged for postage if you request that the copies are to be mailed. The Privacy Official can tell you what the approximate cost will be to copy the information. If you request the information in some form other than photocopies, we will accede to your request if at all possible, and will charge a reasonable cost-based fee for providing the information in the alternative format. The Privacy Official can tell you what the approximate cost will be to reproduce the protected health information in the format you request.

You may also request in writing that we prepare a summary or explanation of your protected health information. We will do so for a fee. We can provide you with a request form, or you may mail a request letter to the Privacy Official. The Privacy Official can tell you what the cost will be to prepare the requested summary or explanation.

Request to Change Protected Health Information. In the event you believe that your protected health information is incomplete or inaccurate, you may request in writing that your protected health information be amended or corrected. The request must be in writing and must explain why you believe the information should be changed. We may deny your request under certain circumstances. We can provide you with a request form, or you may mail a request letter to the Privacy Official.

Request an Accounting of Disclosure and Use of Protected Health Information. Subject to certain exceptions, you have the right to know to whom we have disclosed your protected health information. The exceptions include (1) prior disclosures to you, (2) disclosures you authorized, (3) disclosures to carry out treatment, payment, and healthcare operations. In addition, the disclosures need not include those that took place before April 14, 2003, and in any event, disclosures that took place more than six years prior to your request. If you request an accounting more than once during any twelve-month period, we will charge you a reasonable, cost-based fee for preparing the second response. We can provide you with a request form, or you may mail a request letter to the Privacy Official. The Privacy Official can tell you what the cost will be to prepare the accounting.

Request for Restriction on How Protected Health Information is disclosed to others. You have the right to request that we place additional restrictions on our use and disclosure of your protected health information. We are not required to agree to your request, but if we choose to do so, we will abide by the request, except in certain emergency situations.

Request for Alternative Communication of Protected Health Information. You have the right to request in writing that we communicate with you regarding your protected health information by alternative means or to an alternative location.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Official or with the Secretary of the U.S. Department of Health and Human Services. If you file a complaint, you will not be retaliated against in any way.

Eileen Wilson, Program Director
EOC Adult Day Services
4601 N. Choctaw Rd
Choctaw, OK 73020
(405)-390-4400

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

U.S. Dept. of Health & Human Services
1301 Young St., Suite 1169
Dallas, TX 75202
(214) 767-4056
(214) 767-8940 (TDD)
(214) 767-0432 (Fax)

(HIPAA - Health Insurance Portability and Accountability Act)

Adult Day Services
4601 N. Choctaw Road
Choctaw, Oklahoma 73020
Phone: (405) 390-4400 Fax: (405)390-6637

Re: ____ Date: __________

Dear Physician:

Enclosed please find a copy of Physicians Orders from Eastern Oklahoma County Technology (EOC) Adult Day Center. Although we are not a nursing facility providing 24 hour care, we do provide medical supervision of our clients' needs while they are with us during the day. All participants must have their Physician's Orders to attend our center so we may formulate a complete care plan for each individual.

Please complete the attached orders specifically for your patient's needs, sign them and fax them back to us at (405) 390-6637 when completed.

Sincerely,

Eileen Wilson, R.N.
Program Director
EOC Adult Day Center
(Revised 3/23/11)

Adult Day Services
4601 N. Choctaw Road
Choctaw, Oklahoma 73020
Phone: (405) 390-4400 Fax: (405)390-6637

PHYSICAL EXAMINATION

Participant Name: ____ Date: _________________

DOB: ________________ SSN: ___________________________

Ht: ____ft. ____ in. Wt. ______lbs. BP ________ P______ Resp.________

Allergies: Medication: _____________________ Food: _______________________

MEDICAL DIAGNOSIS:

1. ___________________ 2. _____________________ 3. _____________________

4. ____________________ 5.______________________ 6. _____________________

TEETH: Own Teeth ______ Dentures: Y / N Upper __ Lower __

VISION: good ___ fair___ poor ___ Glasses: Y / N

HEARING: good ____ fair ____ poor ____ Hearing Aide: Y / N Right ___ Left ___

LUNGS: ______________________________ **HEART**: _______________________________

GI: _____________ Constipation ___________ Diarrhea _______ Incontinence ______

URINARY: ___________________ Chronic UTI ________________ Incontinence ______

EXTREMITIES: __________________Edema ________________Skin Condition: __________

MENTAL STATUS:

Memory Loss: Y / N Short term: ____________ Long term: ____________

Dementia: Y / N Type ________________________ Stage _________________

Depression: Y / N Anxiety _____________________ Other _________________

Caregivers Name: _______________________________________

Caregivers Telephone #: ___________________________________**Cell #**:_________________

Physician's Signature: _________________________________ Date: ___________________

Participant Name: _______________________________________ Date: _________________

CURRENT MEDICATIONS Dosage Frequency

____

____

____

____

Standing Orders:
_____ Tums, Antacid, Calcium Carbonate, 750 mg, 2 tabs PRN, for indigestion
_____ Tylenol 325 / 500 mg 1 or 2 tabs q 4-6 hrs PRN pain or elevated temp
_____ Imodium AD 1 caplet after each loose stool x2 PRN diarrhea
_____ OTC throat lozenges 1 for sore throat or cough PRN every hour x 3

Date of last Influenza injection: _________ Current TB Required/Date: __________

DIET: General/Regular: _____________ Other: _______________________________

Limited Concentrated Sweets: _______________

Chewing difficulties: Y / N Swallowing difficulties: Y / N

ACTIVITY LEVEL: Full _____ Limited _____ Explain ________ _______________

Assistive Devices: _____Cane _____Walker _____Wheelchair _____Braces

Fall Risk: Y / N

Physician's Signature: ___________________________________ Date: _______________

Print name: ____

Address: ____

Telephone ____________________________ Fax _______________________________________

(Revised 1/03/11)

Physician Medication Orders

*** This order needs to be separate from the original order of medications taken at home and in a separate medication bottle labeled to reflect the order below for medications given at the Adult Day Center.**

Name:_________________________________ DOB:_______________

SSN:__________________________________

Medication Name	Dose	Route	Frequency/Time

*** Our facility is compliance with State Regulation, Title 310:605-13-2 from the Oklahoma State Department of Health.**

Physicians Printed Name: ______________________________

Physicians Signature: _________________________________ Date: _______________

EOC Adult Day Services:
Program Nurse Signature: _________________________________
Date:_________________
(Revised 3/23/2011)

ARRIVAL/DEPARTURE INFORMATION & TRANSPORTATION AGREEMENT

Participant: ____

Phone # of residence where participant will be transported from: _____________

Scheduled Day of Participation:

Monday	__________	Full Day	__________
Tuesday	__________	Half Day	__________
Wednesday	__________		
Thursday	__________		
Friday	__________		

Regular Arrival Time: ____________________

Regular Departure Time: ___________________

I authorize the E.O.C Adult Day Services staff to transport ______________________________ from residence to the E.O.C. Adult Day Services and to field trips in a vehicle owned & maintained by the E.O.C. Technology Center.

I authorize the following individuals to transport above participant due to illness, disruptive behavior, or non-arrival of caregiver (proof of identity may be required before participant will be released):

1. Name: ____
   Address: ____
   ____
   Phone: ____
   Relationship: ____

2. Name: ____
   Address: ____
   ____
   Phone: ____
   Relationship: ____

____ __________________

Participant/Caregiver/Guardian Signature Date

____ ___________________
Program Staff Date
(Revised 1/03/11)

M.A.R. Identification

Name: _____________________________________ Admit Date: _____________

Diagnosis: ____

Allergies: ____

D.O.B. _______________ Age ____________ Race ________________________

Physician: ____________________________________ Phone: ______________

Hospital Preference: ____

Emergency Transport: ____

Caregiver: ____________________________________ Phone: _____________

Place Photo Here

(Revised 3/23/2011)

INTERDISCIPLINARY PROGRESS NOTES

Last Name	First	Middle
Admitting Date	Attending Physician	

Date	Time	Notes (Entries to be dated and signed and the profession of the recorder shown.)

(Continued on Reverse)

INTERDISCIPLINARY PROGRESS NOTES

Date	Time	Notes (Entries to be dated and signed and the profession of the recorder shown.)

Pre-printed (Briggs)
NURSE'S ASSESSMENT SHEETS
Page 23 & 24 i
In Assessment pkt.

OUTING PERMISSION FORM

Date: __________________

I, ____ give the Senior Adult Day Services permission to transport ______________________________________ on outings whenever weather and conditions permit them to do so. These outings will include trips to the lake, parks, civic and cultural centers and other places of interest in and around the Choctaw and Oklahoma City metro area.

I understand that my signature authorizes blanket permission to be used in the Choctaw, Oklahoma City metro area. Any lengthy trips will require my signature on a specific document giving my permission for the trip. This specific document will state the whereabouts of such an outing.

The Senior Adult Day Services will see that all safety precautions and quality care will be provided to the best of their ability at all times.

____

Participant/Caregiver/Guardian Signature

In case of emergency please notify:

Name: ____Relationship:_____________________

Phone: ____

Physician: _____________________________________ Phone: __________________________

Medical Diagnosis: ____

Allergies Medications/Food: ____

Medications: ____

____

____

(Revised 3/23/2011)

PARTICIPANT'S RIGHTS

Each participant of the Senior Adult Day Services shall be assured of the following rights:

1) To be treated as an adult, with respect and dignity regardless of race, color or creed.

2) To participate in a program of services and activities which promote positive attitudes regarding ones usefulness and capabilities.

3) To participate in a program of services designed to encourage learning, growth and awareness of constructive ways to develop ones interests and talents.

4) To maintain ones independence to the extent that conditions and circumstances permit; and to be involved in a program of services designed to promote independence.

5) To be encouraged to attain self-determination within the adult day center setting, including the opportunity to participate in developing ones care plan for services; to decide whether or not to participate in any given activity, and to the extent possible, in program planning and operation.

6) To be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.

7) To have privacy and confidentiality. (HIPAA Guidelines)

8) To be free of mental and physical abuse.

9) To be free of restraint unless under physician's order as indicated on the individual plan of care.

10) To have access to telephone to make or receive calls, unless necessary restrictions are indicated in the individual care plan.

11) To be free of interference, coercion, discrimination or reprisal.

I HAVE READ THESE RIGHTS (or have had them read to me) AND UNDERSTAND EACH OF THEM.

____ __________________
Participant Signature Date

____ __________________
Caregiver/ Guardian/Staff/Student Signature Date

____ __________________
Program Staff Date

(Revised 1/03/11)

PHOTOGRAPH AND VOICE CONSENT

I authorize taking my picture by photograph, movie, and/or videotape, and/or the recording of my voice by the Senior Adult Day Services staff or persons authorized by the SADS, while participating in the Senior Adult Day Services program.

Furthermore, I consent to and authorize the use and reproduction of any and all photographs, movies, videotapes, including prints, negatives and positives, or sound recordings which they have taken of me or arranged to have taken for publicity, education or informational purposes, without compensation to me. All prints, negatives, positives and sound recordings shall remain the sole property of the Senior Adult Day Services.

I understand that my refusal of consent for photographs or voice release will in no way affect my eligibility for the services of the SADS or the care I receive as a participant in the SADS.

____

Participant/Caregiver/Guardian Date

____

Program Staff Date

(Revised 1/03/10)
(Meets HIPAA Requirements)

TERMINATION OF SERVICES

Termination of services may occur for the following reasons:

1. Participant has an acute illness which the EOC Adult Day Services in unable to manage.
2. If one becomes incontinent of stool and has lost control of bowel function.
3. Participant has a communicable disease.
4. Participant requires constant supervision by a nurse or program staff.
5. Participant is physically abusive.
6. Participant exhibits repeated and uncontrolled verbal abuse.
7. Participant's behavior is sexually inappropriate.
8. Participant requires care and services, which the staff is unable to provide due to advanced medical, physical or psychosocial problems.
9. Participant must not need insulin administration by nursing staff during the day while at the Adult Day Services.
10. Participant has an outstanding bill of 30 days past due.
11. Abuse of services (Late in picking up participant; not ready for pick-up, etc.).
12. Non-compliance with requirements for admission & continual enrollment.
13. Failure to provide a yearly updated physical from your current physician, updated emergency contact form and an updated authorization for release of medical information.
14. Participant poses a danger to self or others.
15. No Alcohol/Tobacco/Controlled Dangerous Substance use or paraphernalia on the premises of EOC Adult Day Services or on EOC Technology Campus.

Note:
An incident report will be completed for any non-compliance of EOC Adult Day Service's guidelines.

DISCHARGE PROCEDURES:

Once admitted to the program and a discharge becomes necessary, the family member and/or caregiver will be notified by the Program Director or designee by letter or telephone.

STATEMENT OF UNDERSTANDING:

I have read the termination criteria for the EOC Adult Day Services program. I agree to give the Program Director full discretion in terminating services, if the participant is not in compliance with the admission requirements at the Adult Day Services.

____ ___________________
Caregiver Date

____ ___________________
Program Staff Date

(Revised 1/03/11)