Joe Evans Respite Care Center
5801 Hugh Howell Rd, Stone Mountain, GA 30087
770-469-4881, Ext 232

Admission Packet

Name _____

Home Address: Street _____

City _____Zip Code _____

Home Phone _____ Cell Phone _____

Birth Date _____

Caregiver Mailing Address: Street _____

City _____ Zip Code: _____

Email: _____

Emergency Contacts

Name	Relationship	Work Phone Work Hours	Home Phone Home Hours	Cell Phone

Start Date: _____ End Date: _____

Reason for Participation Ending: _____

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Attendance Arrangements

Hours per Week: _____

(*center is open 10 am - 3 pm*)

Days per Week: Tues _____ Wed _____ Thurs _____

Transportation arrangements to and from Center: _____

_____

If transportation is provided by someone other than Caregiver, complete below, and indicate days bringing or picking up:

1)Name _____ Phone number: _____

Days Bringing: _____ Days Picking Up: _____

2) Name _____ Phone number_____

Days Bringing: _____ Days Picking Up: _____

3) Name _____ Phone number: _____

Days Bringing: _____ Days Picking Up: _____

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Medical Emergency Release

Should _____require or request emergency medical assistance, I authorize release of all his/her medical information by Joe Evans Respite Care Center staff to such medical facility to which the above named person is transferred, and I assume financial responsibility for all expenses incurred for medical assistance.

Signature _____ Date _____
(*participant, guardian, or caregiver*)

Hospital preference, if possible _____

Personal physician _____ Phone _____

Medicare number _____

Additional insurance policy name and number _____

_____

Allergies _____

Special instructions _____

_____

Medications _____

_____

_____

_____

Note: We do not administer medications – this is for emergency information only.

Please attach copy of Living Will and Healthcare durable power of attorney, if available.

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Personal Information Sheet

Participant's Name _____

Name participant goes by _____

Spouse's name _____

Is spouse: Living _____ Where _____

Deceased _____ When _____

Children:

1. Name _____ Home phone _____

Cell phone _____ Work phone _____

Address: Street _____

City _____Zip Code _____

2. Name _____ Home phone _____

Cell phone _____ Work phone _____

Address: Street _____

City _____Zip Code _____

3. Name _____ Home phone _____

Cell phone _____ Work phone _____

Address: Street _____

City _____Zip Code _____

4. Name _____ Home phone _____

Cell phone _____ Work phone _____

Address: Street _____

City _____Zip Code _____

Siblings and other close family members:

Name	Relationship	Older	Younger	Living?

Where are you originally from? _____

How long did you live there? _____

What was your occupation? _____

What brought you to this area? _____

How long have you lived here? _____

Church affiliation/membership _____

Favorite activities and interests: _____

_____

_____

What are your favorite foods? _____

Any food allergies? _____

Are you more quiet and reserved? Or more outgoing and talkative? _____

What tends to calm or soothe you if you become upset? _____

_____

Who do you have regular contact with, and how often? _____

_____

Do you go on outings? If so, where? _____

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Medical History

Health issues (check all that apply):

Issue	Y/N	Issue	Y/N
Hearing Loss		Gait Problem	
Vision Impairment		Paralysis	
Memory		Rigidity/Stiffness	
Disorientation		Dizzy spells/Vertigo	
Anxiety		Abnormal Movements	
Confusion		Incontinence	
Wandering		Other	
Communication			
Balance			

(please explain in space below)

_____

_____

_____

_____

_____

Have any of the following been diagnosed by a physician? Yes _____ No _____

Diagnosis	Date	Diagnosis	Date
Alzheimer's		Parkinson's	
Dementia		Depression	
Cerebrovascular Disease		Developmental Disability	
Anxiety Disorder		Traumatic Brain Injury	

Other

_____

_____

Major Illness? Yes _____ No _____ If yes, please describe (pulmonary, cardiac, etc.)

_____

_____

_____

Recent Trauma? Yes _____ No _____ If yes, please describe (loss of spouse, pet, etc.)

_____

_____

_____

History of Medical Conditions:

Condition	**Y/N**	**Condition**	**Y/N**
Heart Attack		Kidney or Bladder Disease	
Hypertension/High Blood Pressure		Arthritis	
Irregular Heartbeat		Epilepsy/Seizure Disorder	
Angina/Chest Pain		Paralysis – where?	
Other Heart Condition		Thyroid Disease	
Stroke/Cerebral Hemorrhage		Cancer – Describe	
Diabetes		Head Injury	
Emphysema/Chronic Bronchitis		Meningitis	
Tuberculosis		Alcoholism	
Liver Disease		Psychiatric Illness	
Colon or Bowel Disease		Other	

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Participant Rights and Responsibilities

The participant is entitled to:

1. The right to be treated as an adult with consideration, respect and dignity.
2. The right to be free from physical, mental, sexual, and verbal abuse, neglect, and exploitation.
3. The right to participate in the development of self-confidence with support from the staff of the Center.
4. The right to refuse to participate in any activity of his/her choice while in attendance at the Center.
5. The right to privacy and confidentiality.
6. The right to be fully informed of all the services provided and the charge for each of those services.
7. The right to be informed of the reason and procedures for terminating participation in the program.
8. The right to initiate a complaint with the Director and to be heard on that complaint by the Director.
9. The right for the caregiver to be informed of noticeable changes in the condition of the participant.

As a program participant, the Joe Evans Respite Care Center has the right to expect the participant (and caregiver, where applicable) to meet the following responsibilities:

1. To be under the care of a physician.
2. To supply accurate health history information.
3. To inform the Director of Calvin Cove of any change in health status.
4. When applicable, the caregiver should be available and willing to participate in informational exchanges regarding the participant.
5. To be reasonably considerate and cooperative with all Center personnel as well as other participants, and not to endanger the health and well-being of personnel and participants.
6. To notify the director by the close of business each Monday of the preceding week if you will not be able to keep a regularly scheduled day.
7. To be as prompt as possible each day. Hours are 10:00 a.m. until 3:00 p.m.

I have read and agree to both the participant and program rights and responsibilities.

Signature _____ Date _____

(*participant, guardian, or caregiver*)

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Dear Physician:

Your patient identified below plans to participate as a participant in our respite care program. The Joe Evans Respite Care Center provides respite for caregivers three days a week, Tuesdays through Thursdays, from 10:00 a.m. until 3:00 p.m. Participants must be able to function in a group environment and not require special care, diet or activities. Activities include devotionals, chair exercise, seated games, socializing, and singing. A snack in the morning and a hot lunch are provided. Since participants interact with each other and staff, it is important that they be in good health. Please provide below your statement of the good health and ability of your patient to participate in our program.

Respectfully,

Helen Wilborn, Director
Joe Evans Respite Care Center

Physician's Statement

To Joe Evans Respite Care Center Director:

Based on my examination and familiarity with the medical history of _____ _____ and the information set forth above, I am aware of no reason he or she should not participate in the program at the Joe Evans Respite Care Center. I also attest that he or she does not exhibit signs of communicable disease and is free of TB.

Comments:

_____

_____

Signed: _____ Date: _____

Physician's Printed Name: _____