JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Adult Day Care Services

Melbourne___ Micco___ Titusville ___
❑ Cleared by Nurse Initials: _____

Participant Data Sheet

DOC: _____ Admission Date: _____Free Day: _____

Referral Source: ADI DR Medicaid Friend VA Other_____

Participant Name: _____ Nickname: _____ Sex: Male Female

Address: _____ S.S.#: _____-_____-_____

City: _____ State: _____ Zip: _____ Phone #: (_____)_____

Date of Birth: _____ Age: _____ Ethnicity: _____

Race: _____ Marital Status: _____ Living Situation:

_____Assisted Living
_____Home
_____Home with Help
_____ Other

Caregiver (or Next of Kin) Information :

Name: _____ Address: _____Relationship: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone Day: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Emergency Contact Information: (If same as above check here ☐)

Name: _____ Relationship: _____

Phone Day: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Client Medical Information:

Primary Care Physician: _____ Specialty: _____

Phone: (_____)_____ Fax: (_____)_____

Additional Physicians: _____ Specialty: _____

Phone: (_____)_____ Fax: (_____)_____

☐ Member will need transportation
☐ Faxed Dr. Orders to Dr. Office _____
☐ Physician orders received _____
☐ Admission Packet given to family _____
☐ Financial Assistance/SRA _____

☐ Stand and Pivot ☐ Cane/Walker/Wheelchair
☐ Allergies _____
☐ Continent ☐ Incontinent ☐ Bathroom Assist
☐ Diabetic ☐ Dietary Restrictions
☐ Project Lifesaver
☐ Dentures ☐ Glasses ❑ Hearing Aids

Support Group
ADC Visit
☐ 1st _____
☐ 2nd _____
☐ 3rd _____

Revised 10/26/2021