E.A. Roberts Alzheimer's Center
Mobile | INFIRMARY HEALTH

PARTICIPANT'S HISTORY FROM CAREGIVER

Date:_____

Participant's Name_____

Preferred Name _____

_____

Address_____

City/State/Zip_____Home Phone_____

DOB_____ Age _____ Marital Status: M__S__D__W__

Educational Level_____ Previous Occupation_____

Denomination_____ Church_____

Lives With_____ Relationship_____

Caregiver(s) Name_____

Caregiver(s) Email:_____

EMERGENCY CONTACTS:

Physician:_____ **Phone#**_____

Neurologist:_____ **Phone#**_____

Preferred Hospital:_____

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Participant's Name:_____

Contact List:

Please list the individuals who are authorized to bring your family member to the Roberts Center and also pick them up. ***We can only release the participant to individuals on this list.***

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Participant Name:_____

Contact List:

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

Name:_____ **Relationship**_____

Address_____

Home# _____ **Work#**_____ **Cell#**_____

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Participant Name: _____

MEDICAL INFORMATION:

1. **ALLERGIES?** _____

2. **ILLNESSES*:*** Does participant have now or has he/she ever had any of the following illnesses?

	Yes	No		Yes	No
Asthma	____	____	Tuberculosis	____	____
Diabetes	____	____	Arthritis	____	____
Epilepsy	____	____	Stroke	____	____
Glaucoma	____	____	Heart Disease	____	____
Gout	____	____	Total Knee Replaced	____	____
Hypertension	____	____	Total Hip Replaced	____	____

3. **Flu Vaccination is mandatory before acceptance: (Documentation must be submitted with package) date of Flu Vaccination:_____**

4. **MEDICATIONS*:***

PLEASE REMEMBER: Medications administered at the Center must be sent in the original package from the pharmacy.

Medication	Dosage Amount	Time Meds Are Taken

E.A. Roberts Alzheimer's Center
Mobile | INFIRMARY HEALTH

Dear Family,

In the event that your loved one is in need of an over the counter medication, which of these would you allow our Nurse to administer?

Participant Name: _____

Pain Reliever

_____ **Acetaminophen (Tylenol)**
325mg tablet
2 tablets every 4 to 6 hours

_____ **Ibuprofen (Advil, Motrin)**
200mg tablet
2 tablets every 4 to 6 hours

Antihistamine

_____ **Benadryl**
25mg tablet
1 tablet every 4 to 6 hours

Antidiarrheal

_____ **Imodium**
2mg tablet
2 tablets after first loose stool

Antacid

_____ Generic Antacid/Calcium Supplement

Signature: _____

Date: _____

Participant's Name:_____

NUTRITION*:*

Special Diet?_____

Does he/she drink coffee? Yes □ No □
What does he/she like in coffee? _____

6. **Right Handed □ Left Handed □**

7. **Height____Ft.____In.**

SPECIAL REQUIREMENTS:

	Yes	No
Eyeglasses	____	____
Hearing aid	____	____
Dentures	____	____
Partial Plates	____	____
Does he/she smoke?	____	____
How many packs per day?_____	____	____
Does he/she drink alcoholic beverages?	____	____
Do the medications need to be crushed?	____	____

Does he/she routinely use any special supplies
(Depends, etc.)?_____

Does he/she use any special appliances
(Cane, walker, etc.) or prostheses?_____

Does the participant need assistance in the restroom?

_____

_____

_____

_____

Other considerations: _____

_____

_____

_____

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Participant Name: _____

Does your family member enjoy any of the following? If so, please let us know.

Art: _____

Collections of: _____

Travel: _____

Crafts:

Cooking /baking _____
Gardening _____
Sewing _____

Games:

Bingo _____
Card games
Poker, bridge _____
Bowling _____
Horseshoes _____

Music:

Genres: _____
Artists: _____

TV Shows: _____

Pets:

Dogs _____ **Names** _____
Cats _____ **Names** _____

Sports: _____

Favorite Holidays:

_____ _____

_____ _____

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Participant Name: _____

What does the participant enjoy to do? What are things that are meaningful to the participant?

_____

_____

_____

_____

_____

What did the participant enjoy to do in early adulthood and/or childhood?

_____

_____

_____

_____

_____

Tell us about anyone who is, *or was,* particularly special to the participant... Example: Spouse, parents, siblings, children, grandchildren, best friend, etc.

_____

_____

_____

_____

_____

_____

_____

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Participant Name: _____

These things agitate the participant:

_____

_____

_____

_____

_____

If the participant becomes distressed or agitated the following may help calm him or her down:

_____

_____

_____

_____

_____

Don't be surprised if.....

(Please describe any strange or odd behavior patterns)

_____

_____

_____

_____

_____

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FINANCIAL AGREEMENT

For_____

Participant Name

While participating at the E. A. Roberts Alzheimer's Center, I agree to the following conditions:

The charge for services at the Roberts Center is **$50.00** per day, regardless of the number of hours spent at the Center. This charge covers the cost of day services, activities, meals, snacks and continuous health assessments by the Center's staff. Caregivers are responsible for providing all medications, feeding supplements and supplies such as incontinence undergarments for participants.

Charges are based upon participants' attendance. All charges will be billed the last business day of each month and are due upon receipt.

Checks, debit cards or credit cards (Mastercard, Visa, American Express, and Discover) will be accepted as payment for services.

Name and address to whom bill should be sent:

_____

_____

_____

The above conditions have been reviewed with me. I understand and agree to them.

Signature:_____ **Date:**_____

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PICTURE RELEASE

Date:_____

I, the undersigned, give my permission to the E. A. Roberts Alzheimer's Center to take a picture of _____

Participant's Name

This picture will be placed in the participant's chart and will be kept strictly confidential.

Signature:_____

Responsible Party

Signature:_____

Witness

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PARTICIPANT'S SCHEDULE

Participant's Name: _____ plans to attend the following days each week:

- •Monday _____
- •Tuesday _____
- •Wednesday _____
- •Thursday _____
- •Friday _____
- Alternate Schedule _____

Please explain_____

_____

_____

Charges are based upon this schedule and the schedule will remain in effect unless notified by the responsible party. ***Any changes to this attendance schedule should be made as soon as possible by calling the Center at 435-6950 before 9:30 a.m. of the morning participant is scheduled or there will be a $10 fee to cover lunch. Hours of operation are 7am-5pm. There will be a $1 per minute fee for every minute after 5pm that the participant is not picked up.*** Thank you for your cooperation.

_____ Date:_____

Responsible Party

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AUTHORIZATION FORM - RELEASE OF MEDICAL RECORDS
For use and disclosure of protected health information

Patient Name: _____
Date of Birth: _____ **Social Security #** ____ / ____ / ____
Patient Physician: _____

By signing this Authorization Form, I understand authorization is granted to the provider listed above to release protected health information (PHI), as described in more detail below, to the following person or organization:

NAME OF PERSON OR ORGANIZATION:	**E.A. ROBERTS ALZHEIMER'S CENTER**
STREET ADDRESS:	**169 MOBILE INFIRMARY BOULEVARD**
CITY, STATE, ZIP CODE:	**MOBILE, ALABAMA 36607**
PHONE NUMBER:	**(251) 435-6950 FAX (251) 435-6940**

I authorize the disclosure of the following protected health information:
Requesting:
✓ **Dementia Diagnosis:**
✓ **Other Diagnosis:**

✓ **PHYSICIAN SIGNATURE:** **Date**
PURPOSE OF RELEASE: To confirm eligibility for enrollment in the E. A. Roberts Alzheimer's Center **X** **OTHER REASON:** _____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to the above named physician office.

This authorization will expire when the above named participant is no longer involved in the program provided by the E. A. Roberts Alzheimer's Center.

I understand that the stated recipient may not be subject to privacy laws and that my protected health information may be further disclosed without privacy regulation protection.

_____ _____
Signature of Authorized Representation **Relationship to Participant** **Date**

_____ _____
Signature of Witness **Date**