Ventura County Adult Day Health Care Center
1700 N. Lombard St., #150, Oxnard, CA 93030
Office#: (805) 278-4321 Fax#: (805) 278-4322

New Participant Intake

Name: _____ DOB: _____ Phone #: _____

Referral Source: _____ First visit: _____

Address: _____

Primary Language: _____ Sex: ☐M / ☐F /☐ Decline to Answer/ ☐Other

Marital Status: ☐M /☐ S / ☐D / ☐W

Living condition: ☐B&C/☐Alone/☐ Spouse/☐Other _____

Conservator:/DPOA _____ Phone #: _____

DNR: ☐Yes / ☐No Advanced Directive: ☐Yes /☐No

Emergency Contact 1: _____ Phone #: _____

Relationship: _____ Address: _____

Emergency Contact 2: _____ Phone #: _____

Relationship: _____ Address: _____

Medi-Cal #: _____ Issue date: _____ Currently Eligible: ☐Yes /☐No

Gold Coast #: _____ Issue date: _____ Currently Eligible: ☐Yes / ☐No

Other Health insurance: _____ Number: _____ Issue Date: _____

Case Worker: _____ Phone #: _____ Fax#: _____

	Needs/Goals/Desired Outcomes	Notes
1		
2		
3		

Physician: _____ Phone #: _____ Fax#: _____

Psychiatrist: _____ Phone #: _____ Fax#: _____

Dietary restrictions: _____

Food Prep: ☐Regular/☐Chopped/☐Soft/☐Puree

Ambulatory:☐Yes/☐No

Assisted Device: ☐Cane/☐Walker/☐Wheelchair/Other: _____

Continence: ☐Continent of Bladder/☐Incontinent of Bladder

☐Continent of Bowel/☐Incontinent of Bowel

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Aggression or behavioral issues: _____

Interests: ☐Exercise/☐Dancing/☐Outings/☐ Arts and Crafts/☐Other: _____

Have you attended another ADHC: ☐Yes ☐No Reason for leaving? _____

	Independent *No assistance required.*	**Needs Supervision** *No physical help required, but needs cuing or to be monitored, even with device.*	**Needs Assistance** *Physical help required, even with device.*	**Dependent** *Unable to do for self, even with physical help, cueing or device.*
ADLs				
Ambulation	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Self-Feeding	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
IADLs				
Accessing resources	☐	☐	☐	☐
Hygiene	☐	☐	☐	☐
Meal Prep	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐
Money Management	☐	☐	☐	☐
Transportation	☐	☐	☐	☐

For Office Use Only

		Yes / No	**Notes**
1	Hospitalization (6 Months) Discharge Summary		*If yes, request D/C summary*
2	Medication List/Medication Allergies		
3	H&P, PPD, CXR		*If yes, request last 12 months*
4	Therapy Services (PT, OT, ST) notes for the services		*If yes, request notes*
5	Other		

		Priority Level	**Diagnosis**	**Medications**
1				
2				
3				
4				

Social Worker: _____ Date: _____

Nurse: _____ Date: _____

Program Director: _____ Date: _____

Submit date for Gold Coast: _____ **Received Date from Gold Coast**: _____

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CONSENT FOR RELEASE OF INFORMATION

PARTICIPANT: _____ BIRTH DATE: _____

_____ I (WE), THE UNDERSIGNED, HEREBY CONSENT TO AND AUTHORIZE:

NAME _____

ADDRESS _____

_____

PHONE #: _____ FAX #: _____

TO RELEASE ANY AND ALL INFORMATION REGARDING THE ABOVE-NAMED INDIVIDUAL TO **VENTURA COUNTY ADULT DAY HEALTH CARE** CONCERNING THEM:

_____ PHYSICAL/MEDICAL CONDITION

_____ PSYCHOLOGICAL/PSYCHIATRIC CONDITION

_____ SOCIAL INFORMATION

_____ OTHER: _____

_____ I (WE) ALSO HEREBY CONSENT TO AND AUTHORIZE **VENTURA COUNTY ADULT DAY HEALTH CARE** TO RELEASE ANY AND ALL INFORMATION SPECIFIED ABOVE TO THE ABOVE NAMED INDIVIDUAL/AGENCY/COMPANY.

DATE: _____ _____

SIGNATURE OF PARTICIPANT OR AUTHORIZED REPRESENTATIVE

PLEASE ADDRESS REQUESTED INFORMATION TO VCADHC AT THE ABOVE ADDRESS OR PHONE NUMBERS. THANK YOU FOR YOUR PROMPT RESPONSE.

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