DAYBREAK
SENIOR SERVICES

MEDICAL PROVIDER ASSESSMENT

The individual listed below desires to enroll in DayBreak Senior Services - a Licensed Adult Day Program that provides a safe, engaging space where older adults can stay active, connected, and cared for throughout the day. Our program is thoughtfully designed for individuals living with dementia, as well as other older adults who benefit from structured daytime care. We also assist caregivers who are in need of respite. Each day includes meaningful activities that nurture physical, emotional, social, and cognitive well-being.

In order to protect both the applicant and other participants, it is necessary that we have medical information on each person. This information will also assist the DayBreak personnel in working with this person. Completed assessments can be returned in person by the participant and/or caregiver or can be faxed directly to DayBreak Senior Services at 801-752-3072

NOTE: MEDICAL INFORMATION FORM MUST BE COMPLETED BY PATIENT'S MEDICAL PROVIDER AND UPDATED ANNUALLY

Patient's Name:_____ **Sex:**_____ **DOB:**_____

Provider's Name: _____ **Today's Date**_____

License#/State:_____

Medical Clinic's Name:_____

Address:_____

Phone Number:_____

Date of Last Assessment:_____

Patient Information

Height:_____ **Weight:**_____

Allergies: Please list all known allergies to both foods and medications including patient/family response to known allergens:

_____
_____
_____
_____
_____

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HEALTH HISTORY
If the patient has any of the following conditions, please check the boxes that apply, list when the condition was diagnosed and other relevant information pertinent to their care/condition.

Diagnosis/Condition	✔	**If ✔ please provide month/year diagnosed and other information**
Dementia (Type)		
Hypertension		
Hypotension		
Heart disease		
Stroke		
Congestive Heart Failure		
Asthma		Rescue inhaler (Y/N) Nebulizer (Y/N)
COPD		
Oxygen Use		Concentrator or portable? List Liters/Min:
Diabetes		
Type 1 Type 2		
Controlled with Diet		
CGM		
Test strips		
Insulin Use* Is the patient able to draw and administer? (circle yes/no)		List Name/Dose
Urinary/Bladder Incontinence		
History of UTIs		
Bowel Incontinence		
Briefs Needed		

Mental Health Conditions		
Seizures		Type and history:
Please list any other diagnosis pertinent to care:		

***Note:** DayBreak is not authorized to administer insulin. Participants must be fully independent in insulin management or have a nurse or designated caregiver available to administer it as needed.

SOCIAL AND MENTAL STATUS	
Please rank as follows: 1=Never, 2=Sometimes, 3=Always	
Consider the patient's average social and mental status over the past three months:	
Alert Mentally	
Oriented to time	
Oriented to persons (self, caregivers, family, etc.)	
Oriented to place (ex: familiar environment)	
Short-term memory is good (24 hours or less)	
Long-term memory is good (years)	
Cooperative	
Apathetic	
Hostile	
Physically Aggressive (themselves, others, property)	
Able to make decisions	
Depressed/Discouraged	

Sociable in Small Groups	
Sociable in Large Groups	
Generally positive outlook on life	
Generally negative outlook on life	
Hallucinations	
Delusions	
Exit seeking	
Excessive wandering	
Outburst/Crying/Yelling	
Insomnia	
Excessive sleeping	
Impaired judgement	

OVERVIEW OF PHYSICAL STATUS

Ambulation *Mark All That Apply*

_____ Walks without assistance _____ Gets off balance _____ Needs help of another person

Does the patient wear a brace or use supportive devices?

_____ Braces _____ Walker _____ Cane _____ Wheelchair _____ Artificial limb

Is the patient a fall risk? _____ Yes _____ No

If Yes, please explain:

_____

_____

ROM Limitations

_____

_____

Limitations in ADL's

_____
_____
_____

Limitations with Transfers & Sitting to Standing

_____
_____

Other Physical Limitations (Please describe any other physical limitations below):

_____
_____
_____
_____
_____
_____
_____

Bowel and Bladder Control: (1 Never, 2 Sometimes, 3 Always)

_____ Does the patient wear protective undergarments
_____ Does the patient need to be reminded to use the restroom
_____ Does the patient need to be taken to the restroom*
If so, please describe:_____

_____
_____

*__Note__: Needing assistance in the restroom does not preclude participants from being accepted at DayBreak Senior Services; however, DayBreak can NOT offer services if the participant requires **more than one person** to assist them in the restroom.

Eating Patterns: (1 Never, 2 Sometimes, 3 Always)

_____ Patient is able to eat meals without assistance.
_____ Patient is able to eat meals without assistance but needs help cutting food.
_____ Patient needs to be encouraged to eat.
_____ Patient requires full assistance at mealtimes.

DayBreak provides one lunch as well as morning and afternoon snacks. All meals adhere to the Child and Adult Care Food Program (CACFP) nutrition standards established by the State of Utah. DayBreak is unable to accommodate special diets or individual meal requests. Participants with dietary concerns may bring their own meals and snacks; refrigeration is available. Please note that DayBreak cannot ensure protection against cross-contamination.

Hearing and Vision

Does the patient wear a hearing aid or have they experienced hearing loss? _____

_____

Does the patient hear better out of one ear (which ear)?_____

Does the patient wear glasses/corrective lenses or have impaired vision?_____
_____

Speech and Cognition

Does the patient have any difficulty verbalizing or expressing themself? If yes, please describe:_____
_____
_____

Does the patient have any trouble understanding others? If yes, please describe:_____
_____
_____
_____

MEDICATIONS

1. Please attach a printed list of **ALL** current medications, including dosing and prescription information.
2. **If medications are needed during the day while at DayBreak Senior Services:** DayBreak Senior Services staff is only responsible for the storage, documentation and preparation for self administration of all medications. DayBreak Senior Services can only provide medication at our facility that is included on this medication form, including any PRN and over the counter items. Please complete the entire form for any required medication at DayBreak. Any medication not listed below or missing information will not be administered and will require a new form signed and dated by a physician.

Name/Type of Medication	Dosage/amount to be given	Frequency/times to be administered	Condition for which medication is prescribed	Duration	Any Anticipated reactions to medication

Can the patient self-administer medications? Yes No

MEDICAL PROVIDERS CONSENT FOR EXERCISE AND ACTIVITY

Participants at DayBreak Senior Services have daily opportunities to be involved in any of the following activities:

1. Light exercises from a standing or sitting position.
2. Supervised walks around DayBreak or surrounding areas.
3. Light gardening in our dementia-informed sensory garden.
4. Excursions to various places in the Ogden area including canyon rides to higher altitudes.
5. Group Games like catching/throwing light balls or bowling
6. Arts and crafts activities, including painting and the use of scissors.

Participation in physical activity should be safe and individually appropriate to age and level of physical fitness/function. Please read the bottom portion of this form and indicate whether the above-reference activities (or similar activities) would be appropriate or unsafe for this patient. If one or more of the activities are not appropriate for the patient, please indicate in the space provided any restrictions or recommendations we should be aware of when supervising this particular patient. Please note all activities at DayBreak are optional.

I have read the above information and give my approval for _____ to participate in physical activities.

_____ without restrictions
_____ with the following recommendations or restrictions:_____
_____
_____
_____

MEDICAL PROVIDER SIGNATURE

Clinic Name:_____

Provider Name: _____

Date:_____

Provider Signature:_____

*Additional Notes:*_____
_____
_____
_____