House of Welcome Adult Day Services

1779 Winnetka Road, Northfield, Illinois 60093

Phone: 847.242.6250

Fax: 847.242.6275

Application date:
Participant Demographics:
Participant name:
Preferred name/nickname:
Date of birth: Age:
Participant gender: female
Participant address:
Participant living arrangement: alone
Primary language spoken:
Any other language(s) spoken:
Driving status: still driving
Spouse/Partner (if any)
Name:
Relationship:
Years together:
Occupation:
Still working? Retired?
Primary Caregiver Information
Caregiver name:
Relationship to participant:
Date of birth:
Caregiver address:
Primary phone number:
Secondary phone number (if applicable):
Email:
Secondary Caregiver Information
Caregiver Name:
Relationship to participant:
Date of birth:
Address:
Primary phone number:
Secondary phone number (if applicable):
Email:

Senior & Family Services
North Shore Senior Options
Adult Day Services-
Dementia Care Specialty

National Adult Day Services Association

IADSA

National Association of Social Workers

TOP WORK PLACES 2020

Chicago Tribune

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Emergency Contacts
Name:
Relationship to participant:
Address:
Primary phone number:
Secondary phone number (if applicable):
Email:
Name:
Relationship to participant:
Address:
Primary phone number:
Secondary phone number (if applicable):
Email:

Advance Directives

Does the applicant have any of the following:

☐ Power of attorney for health care
Name: _____
Relationship: _____
Phone number: _____
Email: _____

☐ Power of attorney for property
Name: _____
Relationship: _____
Phone: _____
Email: _____

☐ Legal guardian
Name: _____
Relationship: _____
Phone: _____
Email: _____

☐ POLST (practitioner order for life-sustaining treatment form)

Health Insurance Information
Social security number:
Medicare number:
Please select if you have Medicare Part: A
Name of any additional health insurance providers:
Address of additional health insurance provider:
Phone number of additional health insurance provider:
Long-term care insurance: Yes

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Primary Care Physician Information
Primary Care Physician:
Address:
Phone Number:
Date of last appointment:
Specialist Information
Name of Physician:
Specialty:
Address:
Phone:
Name of Physician:
Specialty:
Address:
Phone:
Name of Physician:
Specialty:
Address:
Phone:
Name of Physician:
Specialty:
Address:
Phone:
Name of Physician:
Specialty:
Address:
Phone:
Name of Physician:
Specialty:
Address:
Phone:
Medical Information
Preferred hospital:
Last hospitalization and reason:
Please list all allergies (food, medication, animal, and/or environmental) and a description of the person's reaction:
Please list any dietary restrictions:

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Functional Changes

Hearing Impairment

Some Loss

- ☐ Right ear
- ☐ Left ear
- ☐ Both ears
- ☐ None

Hearing Aid

- ☐ Right ear
- ☐ Left ear
- ☐ Both ears
- ☐ None

Vision Impairment

Some Loss

- ☐ Right eye
- ☐ Left eye
- ☐ Both eyes
- ☐ None

Glasses/contact lenses: Yes

Mobility

Walks independently: Yes
Needs assistance with walking/transferring: Yes
Uses assistive equipment:

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ None

Toileting

- ☐ Independent
- ☐ Needs some assistance
- ☐ Needs complete assistance

Uses incontinence products: Yes

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Medications (prescription and over-the-counter, including vitamins and supplements)		
Name	Dosage *(mg/frequency taken)*	Reason for taking

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Memory
When did you first notice memory problem?
Date of diagnosis:
Physician or specialist who made diagnosis: geriatrician
Person's understanding of diagnosis:
Please describe any significant changes in person's memory, language skills and behavior:
Is applicant able to read: Yes
Is applicant able to write: Yes