



**Nutrition/Dietary Needs**

Required diet - combinations may be requested.

\_\_\_\_ Regular                      \_\_\_\_ Low NA  
\_\_\_\_ Mechanical Soft            \_\_\_\_ Low Fat  
\_\_\_\_ Lactose Intolerant        \_\_\_\_ 1800 cal. ADA

Can this individual have a regular diet for special occasion or holiday meals?    YES    NO

**\*\*Food Allergies** \_\_\_\_\_

**Status Check**

VISION	good	average	poor	needs corrective item	_____
SPEECH	good	average	poor	needs corrective item	_____
HEARING	good	average	poor	needs corrective item	_____
BALANCE	good	average	poor	needs corrective item	_____
SWALLOWING	good	average	poor		_____
PROBLEM SOLVING	good	average	poor		_____
SAFETY/AWARENESS	good	average	poor		_____
SUPPORT SYSTEM	good	average	poor		_____

The ADC conducts a daily exercise program from a seated position. Is this individual able to participate?    YES    NO    Can this individual attend outings in the community safely?    YES    NO  
Please specify any precautions or restrictions relating to exercise or physical exertion:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The ADC Manager/LSW will complete a Mini Mental Exam or Depression Scale if deemed necessary by the individual, family, ADC staff, physician, or case manager. In what situations would you like this information reported to you?    Never    Results Concerning    Always

ADC participants are able to access outpatient therapy at the Shaller Family Campus Rehabilitation Department. Would this individual benefit from rehab services at this time?

\_\_\_\_ Physical Therapy Order            \_\_\_\_ Occupational Therapy Order            \_\_\_\_ Speech Therapy Order  
Eval & Treat (inc. Aquatic Therapy)            Eval & Treat            Eval & Treat

**\*\* ADC participants MUST have a Mantoux within 3 months prior to enrolling, and yearly thereafter.**

Date of Mantoux \_\_\_\_\_ Results \_\_\_\_\_

If positive, Date of Chest X-Ray \_\_\_\_\_ Results \_\_\_\_\_

Any other information you feel would be beneficial to ADC staff prior to admission to the center -

\_\_\_\_\_  
\_\_\_\_\_

**DO YOU RECOMMEND THIS INDIVIDUAL FOR ADULT DAY PROGRAMMING?**            YES    NO

Code Status -    Full Code            DNR/DNI            Hospice/Comfort Care

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

*\*\* Please double check to ensure all questions have been answered. THANK YOU! \*\**

Manager Signature \_\_\_\_\_ Date \_\_\_\_\_