Consent Form

Riverview Adult Day Health Center
SHAPING THE FUTURE OF ADULT DAY HEALTH SERVICES
est. 1991

Name:

Date:

Riverview ADHC will fax the following forms to the current physician of record.

- Physician's Order
- Medication List

The following forms need to be completed by the POA and returned to Riverview:

_____ Emergency Contact Form
_____ Personal History Form
_____ CACFP Application & Enrollment Form
_____ Emergency Resuscitation Procedures
_____ Authorization for Dispensing OTC Meds

I have been provided with a copy of each policy listed below. Please initial.

_____ Admission Policy
_____ Discharge Policy
_____ Guest's Bill of Rights
_____ HIPAA Practices
_____ Liability Release
_____ Off Premises Release
_____ Photo Release

Agreement

By signing below, I acknowledge that I have read, understand, and consent to the above policies and procedures.

Guest or POA Signature:

Print Signature:

Date:

574.293.6886
2715 E. Jackson Blvd. Elkhart, IN 46516
www.radhc.org

Physician's Order

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Name

Date

Primary Diagnosis

DOB

Allergies (food, medications, or pets)

Please send us a copy of patients lastTB/Mantoux or chest X-ray

Yes	No	
○	○	If patient hasnt had a recent chest X-ray or TB test, may Riverview's LPN administer TB test?
○	○	Does the patient wander away from home or indicate a potential to wander?
○	○	To your knowledge is the patient free from communicable disease?
○	○	Do you think the patient will benefit from enrollment?
○	○	Is the patient combative?
○	○	Can the patient self-administer medication?
○	○	May this patient take part in range of motion activities?
○	○	Any limitations? _____

What is the patient's physical pain on a scale of 1 to 5? _____

Most recent: Blood Pressure ____ Pulse ____ Weight ____

Diet Order: Regular | Diabetic | Low Fat/Low Cholesterol | Mechanical Soft | No added Salt

Physician's name:

Address:

Phone: UPIN#:

Physician's Signature

Date

Medication Log

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NAME: _____

DOB: _____

	Medication / Supplement	Dose	Times Given	Reason Given
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Physician's permission for LPN at Riverview ADHC to clip:
Fingernails: YES/NO
Toenails: YES/NO

Physician's Signature: _____ Date: _____

Emergency Resuscitation Policy & Procedure

Purpose: To inform guests and their legal representatives (Power of Attorney or Healthcare Proxy) of Riverview Adult Day Health Center's procedures in the event of a medical emergency, including when CPR will be performed or withheld based on valid documentation under Indiana law (IC 16-36-5 and IC 16-18-2-167).

Policy Overview: Riverview Adult Day Health Center will respond to any medical emergency involving a guest by contacting 911 immediately. Staff are trained in CPR and will begin resuscitation unless the guest has a valid Out-of-Hospital Do Not Resuscitate (DNR) Order and/or DNR Identification Device as defined by Indiana Code.

Acknowledgment & Signature

I, the undersigned Power of Attorney (POA) or legal representative for the guest named below, acknowledge that I have received, read, and understood the Emergency Resuscitation Policy and Procedures of Riverview Adult Day Center.

I understand that:

- In the absence of a valid DNR Order or DNR Identification Device, CPR will be administered.
- If a valid DNR Order is provided and/or a DNR Identification Device is worn by the guest, CPR will be withheld in compliance with Indiana law.
- It is my responsibility to provide and maintain up-to-date documentation regarding my loved one's resuscitation preferences.

Guest Name	
Date of Birth	

Relationship to Guest:	
Signature / Date	/ /
Print Name	
Witness	

Personal History Form

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First & Last Name:

Name & Relation of person filling out this form:

Getting to know your loved one

Tell us about their education, occupation, interests, and hobbies.

Any bereavement issues?

Any special needs or preferences for care?

Tell us about their favorite food, band, song, person, game, etc

Childhood/Family History (Siblings, children, happy childhood? etc.)

What are you hoping your loved one achieves by attending?

What makes your loved one happy, sad/frastrated?

Additional comments.

Emergency Contact Form

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GUEST INFORMATION	
Full Name	
Address	
Date of Birth	
Living Arrangements	
Insurance Info & SS#	
Referred By	
CAREGIVER/ EMERGENCY CONTACT #1 ☐ caregiver is not emergency contact	
Full Name & Relationship	
Contact Number	
Alternate Number	
Email Address	
EMERGENCY CONTACT #2	
Full Name & Relationship	
Contact Number	
Alternate Number	
EMERGENCY CONTACT #3	
MEDICAL INFO	
Diabetic: YES / NO DNR: YES / NO	Physician: Physician Number:

OTC Meds Form

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AUTHORIZATION FOR DISPENSING MEDICATIONS AT RIVERVIEW ADULT DAY HEALTH CENTER

Medications that have been prescribed by a physician will be given at Riverview ADHC once our nurse has received an order from the physician.

Non-prescription medications, such as aspirin, Motrin, Tylenol, and antacids may be given (PRN) according to label directions if we have a signed authorization from the guest's caregiver or guardian.

Medications must be properly identified. The medication must be labeled with the medication name and dosage or be in its original container.

Complete the lower portion of this form and return to Riverview ADHC with the medication.

Guest Name

Medication Name	Dosage	Time to be Given

I authorize /request personnel at Riverview Adult Day Health Center to give the following Over-the-counter medication to the guest listed above.

Signature of POA/Guardian

____/____/____
Date

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