



# MemoryLane

CARE SERVICES

Dear Caregiver,

Thank you for expressing an interest in the Adult Day Center. We have enclosed several forms.

1. The healthcare provider form should be filled out completely by the physician or other healthcare provider, including a diagnosis of dementia for the person who will be attending. It should also indicate a negative TB test that has been done within the past year (skin test, blood test, or a negative chest x-ray). The healthcare provider's office may fax the completed form to us or you may mail it.
2. Or, if you prefer that we reach out to the physician or healthcare provider for you, please fill out the release of information form, sign it, and return. Be sure to indicate the phone and fax number we should call.
3. Please complete the cost share application, making sure to sign and date on the back of the form.

As soon as all the completed forms have been received, we will call to set an intake appointment. The appointment is usually about one to one and a half hours to complete.

We look forward to meeting you. Please feel free to contact us at 419-720-4940 with any questions or if we may provide any other support.

Sincerely,

Gale Begley  
Activity Director

Cheryl Conley, MA, LSW  
Social Services Director



HEALTHCARE PROVIDER FORM

Adult Day Services Program
2500 North Reynolds Road
Toledo, Ohio 43615
P: 419-720-4940 F: 419-720-4941
www.memorylanecareservices.org

INITIAL MEDICAL FORM /90 DAY UPDATE / STANDING ORDER REQUEST

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

\*\*\*PLEASE ATTACH A CURRENT H&P WITH MEDICATION LIST ALONG WITH THIS COMPLETED FORM\*\*\*

Physician/Healthcare Provider:
Physician/Healthcare Provider Address:
Phone Number: Fax Number:
Has the Applicant been diagnosed with memory impairment? (Check one) \_\_\_ Yes \_\_\_ No
What was the diagnosis? \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_
ALLERGIES/ DIETARY RESTRICTIONS
Allergies and Restrictions YES NO List specific allergies or restrictions
Drug Allergies
Food Allergies
Environmental Allergies
Dietary Restrictions Diet:
Tuberculosis Screening (Negative test result must be within the last year). Choose an option below:
Date of Negative TB Result: \_\_\_\_\_ Skin Test or, \_\_\_\_\_ Chest X-Ray or, \_\_\_\_\_ QuantiFERON Blood Test
Patient Current Medications: \*\* PLEASE ATTACH PRINTED LIST and INCLUDE ANY DRUG ALLERGIES\*\*
List Any Medication Changes or Changes in Medical Conditions: \*\*PLEASE ATTACH CURRENT H&P\*\*
The Patient May Administer Own Medications? [ ] YES [ ] NO
Nurse May Administer Medications If Client is unable at Center? [ ] YES [ ] NO
Standing Orders:
• Tylenol 325 mg 1-2 q 4hr prn, po for pain or fever.
• Ibuprofen 200 mg 1-2 tablets q 4-6 hr. prn po for pain or fever.
• Aerosol treatment as requested by physician order.
• Baby Aspirin for severe chest pain
• Tums
• Pepto Bismol
All Medications Listed Are Approved? [ ] YES [ ] NO
Are medication(s) administration or other service to be provided at Center? [ ] YES\*\* [ ] NO
Other Orders (please specify): \*\* If yes, please attach list of medications and orders.
[ ] Therapeutic meals:
[ ] Nursing services:
[ ] Nutritional consultation:
[ ] Physical Therapy:
[ ] Occupational Therapy:
[ ] Speech Therapy:
[ ] Other:
Are there any physical limitations or medical considerations that would restrict applicant from attending an Adult Day Center \_\_\_ Yes \_\_\_ No If yes, please specify
Special Equipment?
Are there Advanced Directives (DPOA) for healthcare? \_\_\_ Yes \_\_\_ NO
DNR? \_\_\_ Yes \_\_\_ No If yes, please attach a copy Living Will? \_\_\_ Yes \_\_\_ No
Healthcare Provider Signature: Date:
For Office Use Only: Above received and reviewed by MemoryLane Care Services Staff Nurse
Staff Nurse Signature: Date:

**MEMORYLANE CARE SERVICES  
HEALTHCARE PROVIDER AUTHORIZATION TO RELEASE INFORMATION/EXCHANGE  
CONFIDENTIAL INFORMATION**

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I, \_\_\_\_\_ authorize and agree for

Name of Healthcare Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

to release information

to obtain information

to exchange with

on \_\_\_\_\_  
(printed name of individual attending adult day services)

to coordinate services for participation in the adult day center program, I request:

Information to be disclosed: Current History and Physical and Current Medication List

Purpose of disclosure: To coordinate and provide services at MemoryLane Care Services Adult day Center

Information will be disclosed to: MemoryLane Care Services

I understand I have the right to refuse this form, and that I may revoke my consent at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

This information will not be used for any other reason than the purpose stated above

This authorization and release expires on December 31,2019

Staff member requesting release: Gale Begley 1/1/2019  
Staff Printed Name/Signature Date



**ADULT DAY CENTER  
PARTICIPANT COST SHARE ASSISTANCE APPLICATION**

MemoryLane Care Services Adult Day Center is funded in part through the Senior Services Levy for older residents of Lucas County and State of Ohio Alzheimer’s Respite Funds by a grant from the Area Office on Aging.

**PROGRAM PARTICIPANT INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Martial Status: \_\_\_\_\_ Single \_\_\_\_\_ Married

**MONTHLY INCOME**

Please indicate below the participant’s monthly income from all sources including but not limited to income received from the following:

- Social Security
- Annuities
- Disability/sick benefits
- Interest
- Dividends
- Retirement benefits
- Public assistance
- Estate/trust fund payments
- IRA Income
- Farm income
- Veterans benefits
- Pensions
- Rental property income
- Wages/Salary

Source of Income	Amount

**TOTAL INDIVIDUAL MONTHLY INCOME** \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Social Security #: \_\_\_\_\_

To the best of my knowledge, the information provided above is true, accurate and complete disclosure of total income. I understand that these programs are supported, in part, by contributions from participants. If there is a significant change in any of the information provided, it will be my responsibility to notify MemoryLane Care Services.

\_\_\_\_\_  
Signature of person providing information      Relationship      Date

Printed Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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*For office use only*

Monthly Income	Client

Client is eligible for cost share assistance: \_\_\_\_\_ *Yes*      \_\_\_\_\_ *No*

Full day rate: \_\_\_\_\_ Half day rate: \_\_\_\_\_

Cost Share Assistance Amount: \_\_\_\_\_

Transportation rate: \_\_\_\_\_

