SENIOR DAYBREAK

ENROLLMENT PACKET

Thank you for your interest in Senior Daybreak. The following enrollment packet must be completed before a participant may attend the program.

There are a few pages that must be signed by a physician:

The Health Status Inquiry (page 4) and Medications List (page 5) must be reviewed and **signed by a physician**. If you are having difficulty obtaining these forms and signatures, please notify Senior Daybreak staff and we will try to help you.

The MOST form (Colorado Medical Orders for Scope of Treatment) (page 8 and 9) needs to be completed and **signed by a physician.**

Please call and make an appointment to return this packet to Senior Daybreak. We will go over the packet and discuss a schedule. If we will be transporting your loved one, we will need to work them into the current transportation schedule. We will make a copy of this enrollment packet for you for your records.

Please call 241-7798 if you have any questions.

ENROLLMENT FORM

PARTICIPANT

Date__________________

Participant's Last Name: _________________________ First Name: _______________________ M.I.: ___

Social Security Number: ________________________________ Birth Date: _____________ Age: ________

Living Situation: ☐ by self ☐ w/spouse ☐ w/adult child ☐ w/other family member ☐ care facility

Address: ___________________________________ City: _______________ State: ______ Zip: ________

Responsible Party:___________________________ Relationship ___________ Phone: H:________________

Cell:___________________ Email ____________________________________

Billing: ☐ Private Pay ☐ VA - Social Worker:_________________________ Ph________________

☐ Medicaid- Case Manager: _________________________ Ph_____________________

☐ Current Hilltop resident? Y/N If yes, please indicate program________________________________

GENERAL PERSONALITY TRAITS

Describe their personality: ____

____

____

FAMILY

Participant's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse Name (even if deceased): ____

# of Children: ______ First Names: ____

____

Names and kind of important pets: ____

HISTORY

Ethnic Origin: ☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Asian ☐ Other __________

Birth Place:______________________________ Grew up where?:___________________________________

Former Occupation(s): ____

____

Veteran? ☐ No ☐ Yes Branch of Service: ____

List any major life events that the participant might talk about:_______________________________

____

CURRENT ABILITY LEVEL

Mental Status: Awareness of People and Surroundings: ☐ High ☐ Medium ☐ Low

Confusion: ☐ None ☐ Mild ☐ Medium ☐ Extreme

Short term memory loss: ☐ None ☐ Mild ☐ Medium ☐ Extreme

Long term memory loss: ☐ None ☐ Mild ☐ Medium ☐ Extreme

Language: ☐ Conversational ☐ Some Difficulty ☐ Great Difficulty ☐ Non-Communicative

Walking: ☐ Independent ☐ Shaky or Unsure ☐ Cane ☐ Walker ☐ Wheelchair

Toileting: ☐ Independent ☐ Reminders ☐ Incontinent ☐ 1 person assist ☐ 2 person assist

Type of adult protective products used: ___________________________________

Eating: ☐ Independent ☐ Needs Assistance Cutting ☐ Needs Supervision to Avoid Stuffing

☐ Needs to be Fed ☐ Special Diet (See Dietary Form) ☐ Dentures

Bathing: ☐ Independent ☐ Needs Reminders ☐ Needs Assistance ☐ Usually a Battle

Dressing: ☐ Independent ☐ Needs Assistance ☐ Needs to be Dressed by Caregiver

Vision: ☐ Good ☐ Glasses ☐ Macular Degeneration ☐ Blind

Hearing: ☐ Good ☐ Poor ☐ Hearing Aids: ☐ Left ☐ Right

Smoking: ☐ No ☐ Yes: __Independent __Needs Supervision Frequency: approx. ____ per day

PHYSICAL LIMITATIONS

Describe limitations that would affect ability to do activities: _______________________________________

____

____

ACTIVITY INTERESTS

Past Activity Interests/Hobbies: ____

____

Current Activities: ____

____

Goal/Reason for attending program: ____

SPECIAL NOTES: Important things Daybreak should probably know:

____

____

____

____

PRIMARY CAREGIVER

Caregiver's Name: ____

Relation to participant: ☐ Spouse ☐ Adult Child ☐ Grandchild ☐ ___________-in-Law

☐ Sibling ☐ Other ____

Caregiver's Address: ____________________________City: _____________ State: ___

Zip: ____ Home Phone: _______________ Cell Phone: _____________Work Phone: ____________

How long has Caregiver been caring for participant?________________________

Does Caregiver have prior personal or professional caregiving experience? ☐ Yes ☐ No

Does Caregiver have family/friend physical support? ☐ Yes ☐ No Emotional support? ☐ Yes ☐

No Current Caregiver Stress Level: ☐ Low ☐ Medium ☐ High ☐ Extreme

Would Caregiver be interested in attending a support group? ☐ Yes ☐ No

Is Caregiver interested in learning more about: ☐ Support Groups ☐ Education Programs

How did Caregiver hear about Senior Daybreak?____

The Participant and/or Caregiver choose to willingly participate in Senior Daybreak.

☐ Yes

☐ No

HEALTH STATUS INQUIRY

TOP SECTION TO BE COMPLETED BY RESPONSIBLE PARTY
BOTTOM SECTION TO BE COMPLETED & SIGNED BY PRIMARY PHYSICIAN

Participant:____Date:________________

Age_______ Birth Date____________________ Social Security (last 4) ______________________

Current Health Concerns: ____

____

Brief Past Medical History: ____

____

Allergies: ____________________________________Oxygen use:❒ No❒ Yes (____Liters p/m)

Mental Status: ❒ No Confusion ❒ Mild Confusion ❒ Medium Confusion ❒ Extreme Confusion

Primary Physician:____

Physician Office Name: ____

Physician Address: ____

Physician Phone:________________________________ Fax: ___________________________

Hospital Preference: ____

MEDICAL RELEASE

I hereby authorize ____*(Physician's name printed)* to release the medical information below, and any other pertinent information necessary for the care and health monitoring of the above-named participant/patient, to **Senior Daybreak of Hilltop.**

____Date: _______________________

Signature of Responsible Party

_______________________________________ ______________________

Print Name *Relationship to Patient*

PHYSICIAN'S SECTION

Patient Diagnoses (include dementia if dx): ____

Do you recommend the specialized adult day care services of Senior Daybreak?

for this patient? ❒ Yes ❒ No If no, why? ___________________________

Do you recommend any physical restrictions for this patient? ❒ Yes ❒ No

If yes, describe: ____

Do you recommend any diet restrictions for this patient? ❒ Yes ❒ No

If yes, describe: ____

Have you referred this patient for: ❒ physical, ❒ occupational, or ❒ speech therapy? ❒ No

Physician's Signature: ____________________________________Date: ___________________

Hilltop COMMUNITY RESOURCES SENIOR DAYBREAK

MEDICATION LIST

Participant Name: ____ Date: ___________

Will prescription medications need to be given by staff at Senior Daybreak? __yes _no

Will over-the-counter medications need to be given by staff at Senior Daybreak? __yes __no

Please include all medications taken by participant on this sheet whether given at Senior Daybreak or not. This information is vital to give to medical personnel in case of emergency.

CURRENT **PRESCRIPTION** MEDICATIONS

Medication	Dosage	Time(s) of day to be given	Purpose of medication	**Check if given at Daybreak**

CURRENT **OVER-THE-COUNTER** MEDICATIONS

Medication	Dosage	Time(s) of day to be given	Purpose of medication	**Check if given at Daybreak**

Examples: Pain Relievers, Antacids, Stool Softeners, Cough Drops, Vitamins, Ointments, (etc.)

Any medication needed during program hours is brought in its original container so we may make a copy of the label. Medications will be stored in a locked closet and administered by a QMAP qualified person or RN, regardless of whether the participant might be cognitively capable of keeping medication on his/her person and self-administering. Are you in agreement with this Senior Daybreak policy for this Participant? yes __no___. If no, please call us to discuss.

Physician's Signature: ____**Date:** ____________________

DIETARY INFORMATION

Participant Name: ______________________________________ Date: ______________

Senior Daybreak receives the Lunch meal from The Commons Assisted Living which is a healthy, made-from-scratch, daily special. Senior Daybreak will provide the monthly menu to families at the beginning of the month. Morning and afternoon snack foods are purchased from Sam's Club or the grocery store and are in compliance with USDA standards.

Senior Daybreak is not able to provide special diets such as gluten-free, diabetic, pureed, low salt (etc.). We can, however, provide sugar- free desserts. We do not put salt and pepper on the table, but will provide it to those who ask, and can monitor a person from adding more salt to their meal if necessary.

Senior Daybreak can provide salads or vegetables to those participants who are vegetarians, but the salad choices are very limited. Daily vegetables are greatly varied. Family may supplement proteins.

Senior Daybreak does not usually serve seconds unless there is extra food available for all that want a second portion.

Families may request to provide special beverages or food for dietary restrictions. Requests need to be assessed, included into the Care Plan and approved by program manager. Program may or may not be able to approve request. Other than sugar-free desserts, Senior Daybreak cannot purchase any special food items for individual participants.

Senior Daybreak may provide limited assistance to those participants who cannot eat independently.

Meal needs: ❒ Regular Food ❒ Cut Up Food

❒ Diabetic but eats regular food, can have regular desserts
❒ Diabetic with strict restriction of sugar free desserts and monitored proportions
❒ Vegetarian ❒ Low Salt

Food Allergies: ____

Appetite is usually: ❒ Large ❒ Medium ❒ Small

Food Likes: ____

____

Food Dislikes: ____

____

Preferred Beverages: ❒ Water ❒ Milk ❒ Tea _
❒ Coffee: ❒ Black ❒Cream ❒ Sugar ❒ Splenda ☐ Other(s)______________ (Family to provide)

Diet notes: ____

____

EMERGENCY INFORMATION

Participant Name: ______________________________________ Date: _______________

If there is a medical emergency, Senior Daybreak staff will call the primary caregiver and the supervising nurse at the same time. Based on the circumstances, and input from both the nurse and the primary caregiver, a judgment call will be made on whether to call 911 for emergency personnel and ambulance transport, or non-emergency ambulance transport, or pickup by the caregiver to be taken to the ER, doctor, or home. Please list the proper individuals to call in case of an emergency.

Primary Caregiver: ______________________________ Relationship: ___________________
Address: __________________________________ City: _____________ Zip: ____________
Home: ___________________ Work: ____________________ Cell: _____________________

2nd Contact Person: _____________________________ Relationship: ___________________
Address: __________________________________ City: _____________ Zip: ____________
Home: ___________________ Work: ____________________ Cell: _____________________

3rd Contact Person: _____________________________ Relationship: ___________________
Address: __________________________________ City: _____________ Zip: ____________
Home: ___________________ Work: ____________________ Cell: _____________________

ADVANCE DIRECTIVES

Senior Daybreak is required by the state to have information on file regarding the Advanced Directives that are in place and to provide information to the family if not. (See Advance Directives flyer in packet for explanation of the following directives). Check the directives that have been established:

❒ Durable Medical Power of Attorney
Name of POA Agent:________________________________ Phone:___________________
❒ Durable Financial Power of Attorney
Name of POA Agent:________________________________ Phone:___________________
❒ Living Will

Please complete the MOST form (see next page), or provide a copy if you have already completed one. This form must be signed by the physician. Senior Daybreak MUST HAVE A SIGNED COPY ON FILE. If advanced directives are listed in a Living Will, this can be accepted in place of the MOST form.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST** follow these orders, **THEN** contact Physician, Advanced Practice Nurse **(APN),** or Physician Assistant **(PA)** for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or Bis not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- Everyone shall be treated with dignity and respect.

Legal Last Name		
Legal First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive.
If yes and available, review for consistency with these orders and update as needed. (See additional instructions on page 2.)

A
Check one box only

CARDIOPULMONARY RESUSCITATION **(CPR)** *******Person has no e.ulse and is not breathing_.******

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
When not in cardiopulmonary arrest, follow orders in Section B.

B
Check one box only

MEDICAL INTERVENTIONS *******Person has e.ulse and{_or is breathing_.******

☐ **Full Treatment-primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment-goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment-primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

Additional Orders:

C
Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION *Alwa)!S* **oft.ertood** & *water b)! mouth* **ilteasib/e.**

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices-further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOSTform")for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders:

D

DISCUSSED WITH (check all that apply):

D Patient
D Agent under Medical Durable Power of Attorney
D Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
D Legal guardian
D Other: ______________________

SIGNATURES OF PROVIDER **AND** PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE *(MANDATORY)*

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment,* they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/legal Decision Maker Signature *(Mandatory)*	***Name*** *(Print)*	*Relationship/ Dedsion maker status (Write ,,.selr' if patient)*	*Date Signed {Mandatory; Revokes afl previous MOST forms)*

Physician I APN I PA Signature *(Mandatory)*	***Print Physician I APN I PA Name, Address, and Phone Number***	*Date Signed (Mandatory)*
Colorado License#:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

ADDITIONAL INFORMATION: *Please provide contact information below, in case follow up or more information needed.*

Patient Legal last Name	*Patient legal First Name*	*Patient Middle Name (if any)*	*Patient Date of Birth*
Prfmary Contact Person for the Patient	*Refationshfp and/or MDPOA, Proxy, Guardian*	*Phone Number/emaif/Other contact information*	
Heafthcare Professfonaf Preparing Form	*Preparer Titfe*	*Phone Number/Email*	*Date Prepared*
Patient Primary Diagnosis	*Hospice Program (if applicable) /Address*		*Hospice Phone Number*

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

For more information, please refer to the "Getting the MOST Out of the Medical Orders for Scope of Treatment: Guidelines for Healthcare Professionals," www.ColoradoMOST.com

CompJeting_ the MOST form:

- MOST form master may be downloaded from www.ColoradoMOST.com and photocopied onto **Astrobrights'" "Vulcan Green"** or **"Terra Green"** 60Ib paper. This special paper is strongly encouraged but not required. Visit www.ColoradoMOST.com for a link to paper suppliers.
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory. "A** healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

Following_ the Medical Orders:

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders *medically* inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or Bis not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

Reviewing_ the Medical Orders:

- These medical orders should be reviewed
  - regularly by the person's attending physician or facility staff with the patient and/or patient's legal decision maker;
  - on admission to or discharge from any facility or on transfer between care settings or levels;
  - at any substantial change in the person's health status or treatment preferences; and
  - when legal decision maker or contact information changes.
- If substantive changes are made, please complete a new form and void the replaced one.
- **To void the form, draw a line across Sections A through C and write "VOID" in large letters. Sign and date.**

REVIEW OF THIS COLORADO MOST FORM

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ New Form Completed
			D No Change D New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Colorado Advance Directives Consortium, www.ColoradoMOST.com