**The Center**

**ASSISTED LIVING INTAKE CHECKLIST**

Name: ___________________________ Date of Birth __________________

*All documents should be submitted to Records Management within 5 working days prior to the entry date.*

### PRE – ADMISSION DOCUMENTATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Documents Required Before Starting</th>
<th>Additional Documents – if available</th>
</tr>
</thead>
<tbody>
<tr>
<td>______ Application for Services #145</td>
<td>______ Copy of Birth Certificate</td>
</tr>
<tr>
<td>______ Admission Funding Data #151</td>
<td>______ Copy of Texas Identification Card</td>
</tr>
<tr>
<td>______ Copy of Letter of Guardianship and Verification of annual renewal (if applicable)</td>
<td>______ Copy of Social Security Card</td>
</tr>
<tr>
<td>______ DMR – Determination of Mental Retardation or Psychological Evaluation (less than 10 yrs old)</td>
<td>______ Copy of Medicaid Card</td>
</tr>
<tr>
<td>______ Physical Examination #04 (less than 1 yr old)</td>
<td>______ Copy of Medicare Card</td>
</tr>
<tr>
<td>______ Admissions Medication History #18</td>
<td>______ Copy of HMO/PPO/Other Insurance Card</td>
</tr>
<tr>
<td>______ Physician’s Orders #08 (if applicable)</td>
<td>______ Copy of SSI Award Letter</td>
</tr>
<tr>
<td>______ Copy of TB Test #76 (less than 1 year old)</td>
<td></td>
</tr>
<tr>
<td>______ Copy of DPT/td #120 (less than 10 yrs old)</td>
<td></td>
</tr>
</tbody>
</table>

### MOVE IN DOCUMENTATION REQUIREMENTS

*(Initial Assisted Living Support Plan packet to include the following documents.)*

<table>
<thead>
<tr>
<th>Initial Assisted Living Services and Supports Plan #12AL</th>
<th>Rights Acknowledgment #111</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement for Residential Services</td>
<td>Notice Of Privacy Practices #110</td>
</tr>
<tr>
<td>Financial Authorization Form #59</td>
<td>Program Information Receipt #113</td>
</tr>
<tr>
<td>Emergency Authorization #41</td>
<td>24 Hour Activity Schedule #128</td>
</tr>
<tr>
<td>Advanced Directives #45</td>
<td>Residential Training Objective #25 (if applicable)</td>
</tr>
<tr>
<td>Medication Policy #06</td>
<td>Residential Service Objective #38 (if applicable)</td>
</tr>
<tr>
<td>Physician’s Orders for Self Administration of Medication #80</td>
<td>Full Body Photo</td>
</tr>
<tr>
<td>Resident’s Rules #101</td>
<td>Head and Chest Photo</td>
</tr>
<tr>
<td>Residential Rights #127</td>
<td></td>
</tr>
</tbody>
</table>

### 30 DAY ASSESSMENT DOCUMENTATION REQUIREMENTS

*(ALSO IF APPLICABLE)*

<table>
<thead>
<tr>
<th>30 Day Assessment Interim Staffing #102</th>
<th>Day Program Personal Skills Profile #107</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Personal Skills Profile #160</td>
<td>Day Program Training Objective #25</td>
</tr>
<tr>
<td>Inventory of Belongings (Female) #162</td>
<td>Day Program Accountability Chart #13M</td>
</tr>
<tr>
<td>Inventory of Belongings (Male) #163</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Nursing Assessment #8584</td>
<td></td>
</tr>
</tbody>
</table>

### OTHER DOCUMENTS RECEIVED

<table>
<thead>
<tr>
<th>Other</th>
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<td>Other</td>
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</tbody>
</table>
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

GENERAL INFORMATION
DATE OF APPLICATION: ___________________________

NAME OF APPLICANT: _________________________________________________________
Last Name    First Name    Middle Initial

PRESENT ADDRESS: Street Address: ____________________________________________
City: _____________________ State: _____   Zip: ____________

PHONE NUMBER: [Home] (____)________________   [Emergency] (____)_________________

EMERGENCY CONTACT: ________________________   RELATIONSHIP: _______________

DATE OF BIRTH: ___________   AGE: _____   S/S #___________________   SEX: ☐ Male ☐ Female

MARITAL STATUS: ☐ Single   ☐ Married   ☐ Divorced   ☐ Widowed

PRIMARY LANGUAGE: ☐ English   ☐ Spanish   ☐ Other, specify: _______________________

COMMUNICATION MODE: ☐ Verbal   ☐ Gestures   ☐ Vocalizations   ☐ Sign Language

COMMUNICATION DEVICE(S): _______________________   RELIGION: _________________

HAIR: ________EYE: _______HEIGHT: _________WEIGHT: _______ETHNICITY: _______

CLIENT OR GUARDIAN ________________________________ DATE: _____________________

Signature

FOR OFFICE USE ONLY

PROGRAMS APPLYING FOR
☐ AAC - West Dallas   ☐ Cullen - Assisted Living   ☐ Willow River Farm   ☐ HCS Foster Companion Care
☐ ATES – Day Habilitation   Room #________   House # ________   ☐ HCS Supervised Home Lvg
☐ ATES - Vocational   ☐ Cullen - Independent Living   ☐ WRF-Assisted Living   ☐ HCS Residential Supervised
☐ ATES – Young At Heart   Room #________   House # ________   ☐ WRF-Day Program
☐ WRF-Assisted Living

FUNDING
☐ Private Pay   ☐ TXHML   ☐ ICF/MR   ☐ The Center HCS

☐ Medicaid MCO   ☐ Contract   ☐ Other HCS: _________________________________

DATE FUNDING VERIFIED by ADMISSIONS COORDINATOR: _____________________

ADMISSION DECISION   Date Applicant Informed of Decision: _____________________
☐ Approved   ☐ Approved - Waiting List   ☐ Not Approved
Enter Date: ___________   Entered on List: ___________   Reason: _______________________

Assigned Program Coordinator: ________________________________ ________________________________

Signature of Social Worker   Signature of Dept. Director/Manager   Signature of Chief Operating Officer
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: ________________________   DOB: _______________   DATE: _______________

FAMILY/CONTACTS

NAME OF FATHER: ____________________________________________________________

Describe Contact: ____________________________________________________________

Address: ____________________________________________________________________

City: ________________________ State: _________ Zip: __________

Phone: [Home] (___)______________ [Work] (___)________________________

Phone: [Cell] (___)______________ Email Address: ____________________________

NAME OF MOTHER: ____________________________________________________________

Describe Contact: ____________________________________________________________

Address: ____________________________________________________________________

City: ________________________ State: _________ Zip: __________

Phone: [Home] (___)______________ [Other/Emergency] (___)__________________

Phone: [Cell] (___)______________ Email Address: ____________________________

NAME OF EMERGENCY CONTACT: ______________________________________________

Relationship to Applicant: ____________________________________________________

Address: ____________________________________________________________________

City: ________________________ State: _________ Zip: __________

Phone: [Home] (___)______________ [Other/Emergency] (___)__________________

Phone: [Cell] (___)______________ Email Address: ____________________________

NAME OF EMERGENCY CONTACT: ______________________________________________

Relationship to Applicant: ____________________________________________________

Address: ____________________________________________________________________

City: ________________________ State: _________ Zip: __________

Phone: [Home] (___)______________ [Other/Emergency] (___)__________________

Phone: [Cell] (___)______________ Email Address: ____________________________
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: __________________________ DOB: ______________ DATE: ______________

BACKGROUND

PLACE OF BIRTH: City: ______________ County: ______________ State: _______

US CITIZENSHIP  □ Yes  □ No  LEGAL STATUS  □ Competent  □ Incapacitated

if has a court appointed Guardian:
Name of Guardian: ________________________________________________________
Relationship to Applicant: _____________________________________________
Address: ________________________________________________________________
City: __________________________ State: ___________ Zip: __________

Phone: [Home] (____)_____________ [Other/Emergency] (_____)

Date Appointed by Court: ___________________ Court Case Number: ____________

County: __________________________ State: __________________

INSURANCE

MEDICAID  □ Yes, Number (#): _________________________
□ No, have applied and been denied
□ No, have never applied

MEDICARE  □ Yes, Number (#):
□ No, have applied and been denied
□ No, have never applied

HMO/PPO  □ Yes, Policy Number (#): _________________________

Company Name: ____________________________________________
□ No

LIFE INSURANCE  □ Yes, Policy Number (#): _________________________
(needed only if applying for a residential program)

Company Name: ____________________________________________
□ No

BURIAL INSURANCE  □ Yes, Policy Number (#): _________________________
(needed only if applying for a residential program)

Company Name: ____________________________________________
□ No

INCOME

ESTIMATED ANNUAL INCOME OF APPLICANT: ______________________________

PRIMARY SOURCE OF INCOME: (check one)
□ SSI  □ Wages  □ Other, specify: ____________________________________________

OTHER MEANS OF FINANCIAL SUPPORT: ________________________________

DESCRIBE APPLICANT’S PARTICIPATION IN COMMUNITY/NEIGHBORHOOD:
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________DOB: _______________DATE: _______________

MOBILITY/SELF CARE

Mobility  (check one)
☐ Walks Independently  ☐ Walks with Assistance from Others
☐ Uses Wheelchair Independently  ☐ Uses Wheelchair with Assistance from Others

Describe/List Any Adaptive Equipment Used for Mobility: ____________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
Describe Assistance Needed to Get from One Place to Another: ________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Eats Meals Independently  ☐ Yes  ☐ No, please describe help needed: __________________________
_______________________________________________________________________________________

Bathes Independently  ☐ Yes  ☐ No, please describe help needed: __________________________
_______________________________________________________________________________________

Dresses Independently  ☐ Yes  ☐ No, please describe help needed: __________________________
_______________________________________________________________________________________
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________ DOB: _______________ DATE: _______________

Uses Rest Room Independently  □ Yes  □ No, please describe help needed: __________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Describe Any Other Assistance Needed/Comments: ________________________________
___________________________________________________________________________________
___________________________________________________________________________________
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MEDICAL/HEALTH CARE

PRIMARY PHYSICIAN: ________________________________________________________________

Address: ________________________________________________________________
City: ________________________________ State: ___________ Zip: ___________

Phone: [Office] (____)_____________________ [Fax] (____)________________________

KNOWN ALLERGIES (food, medication, other): _________________________________________
___________________________________________________________________________________

EXISTING MEDICAL CONDITIONS/DIAGNOSES: ______________________________________
___________________________________________________________________________________
___________________________________________________________________________________

SEIZURES  □ No  □ Yes, please explain: _______________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

HEARING IMPAIRMENT  □ No  □ Yes, please explain: ________________________________
___________________________________________________________________________________
___________________________________________________________________________________
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: ______________________ DOB: __________ DATE: __________

VISION IMPAIRMENT  □ No  □ Yes, please explain: __________________________
_____________________________________________________________________
_____________________________________________________________________

ADAPTIVE EQUIPMENT/POSITIONING  □ No  □ Yes, please explain: ___________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

TAKES MEDICATIONS INDEPENDENTLY  □ Yes  □ No, please explain: ___________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

MEDICAL/HEALTH CARE

CURRENT MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date Prescribed</th>
<th>Reason for Use</th>
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</table>

MEDICAL HISTORY please list/describe hospitalizations and significant illnesses

<table>
<thead>
<tr>
<th>Date</th>
<th>List or Describe Hospitalization or Surgery or Illness</th>
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</table>
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: ___________________________ DOB: ___________ DATE: ___________

ADDITIONAL COMMENTS RELATED TO MEDICAL/HEALTH CARE: ___________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

FOR OFFICE USE ONLY

Advance Directive  □ No  □ Yes (attach copy)  DNR Order  □ No  □ Yes (attach copy)

INTERACTIONS

DESCRIBE HOW APPLICANT INTERACTS WITH OTHERS: __________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

DESCRIBE BEST WAY TO INTERACT WITH THE APPLICANT: _______________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

DESCRIBE THINGS THAT THE APPLICANT LIKES OR THAT MOTIVATE HIM/HER:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

_________________________________________________________________________
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: ______________________ DOB: __________ DATE: __________

DESCRIBE APPLICANT’S ABILITY TO MAKE CHOICES: ______________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

DESCRIBE ANY SIGNIFICANT BEHAVIORS: ______________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

EDUCATION/SERVICES/EMPLOYMENT

EDUCATION (schools attended)

<table>
<thead>
<tr>
<th>Name of School</th>
<th>City</th>
<th>State</th>
<th>Dates Attended From/To</th>
<th>Highest Grade Completed</th>
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</thead>
<tbody>
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</table>

CURRENT SERVICES (includes residential, vocational, job training, in-home care)

<table>
<thead>
<tr>
<th>Date Services Began</th>
<th>Type of Service(s)</th>
<th>Agency Providing the Service(s)</th>
<th>City</th>
<th>State</th>
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</thead>
<tbody>
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</table>
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________  DOB: _______________  DATE: _______________

PREVIOUS SERVICES  *(includes residential, vocational, job training, in-home care)*

<table>
<thead>
<tr>
<th>Dates of Service From/To</th>
<th>Type of Service(s)</th>
<th>Agency that Provided the Service(s)</th>
<th>City</th>
<th>State</th>
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<tbody>
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</table>

CURRENT EMPLOYMENT

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Job Title</th>
<th>Hire Date</th>
<th>Wage</th>
<th>Location</th>
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<tbody>
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</table>

PREVIOUS EMPLOYMENT

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Job Title</th>
<th>Dates of Employment</th>
<th>Wage</th>
<th>Location</th>
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</thead>
<tbody>
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</table>

TRANSPORTATION

TRANSPORTATION *(check all that apply)*

- ☐ Uses City Bus/Cab Independently
- ☐ Uses Para Transit (Metro Lift)
- ☐ Family/Friends Provide Transportation
- ☐ Agency (group home) Provides Transportation
- ☐ Operates Own Vehicle (Car/Bike)
- ☐ Other, ________________________________

Comments: __________________________________________________________________________
____________________________________________________________________________________
# THE CENTER
## APPLICATION FOR SERVICES / ENROLLMENT FORM

**NAME:** __________________________  **DOB:** ______________  **DATE:** ______________

<table>
<thead>
<tr>
<th>Has the Applicant ever been Convicted (or adjudicated) of a public offense?</th>
<th>☐ No</th>
<th>☐ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, will the conviction interfere with the admission at The Center?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>If yes, please explain:</td>
<td>________________________________________</td>
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</table>

*Please submit documents requested on the Application for Services Documentation Checklist.*

*Your application will not be considered complete until all documents have been given to The Center’s Admissions Coordinator.*

*Please contact The Center’s Admissions Coordinator (713) 525-8318 with any questions or for assistance.*

---

I agree that the information provided is, to the best of my ability, accurate and complete.

<table>
<thead>
<tr>
<th>Applicant Signature</th>
<th>Date</th>
<th>Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
THE CENTER
ADMISSION FUNDING DATA

NAME OF INDIVIDUAL:
Last Name: ____________________________________________
First Name: ____________________________________________
Middle Initial: _________________________________________

PRESENT ADDRESS:
Street Address: ________________________________________
City: ___________________ State: _______ Zip: _________

PHONE NUMBER: [Home] (____)____________ [Other/Emergency] (____)___________

DATE OF BIRTH: ___________________ GENDER: □ Male □ Female

SOCIAL SECURITY NUMBER: _______________________________________________

<table>
<thead>
<tr>
<th>PROGRAM(S)</th>
<th>LOCATION CODE</th>
<th>ADMISSION DATE</th>
<th>FUNDING SOURCE(S)</th>
<th>FUNDING AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Activity Center</td>
<td>AAC</td>
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<tr>
<td>ATES - Caning</td>
<td>CAN</td>
<td></td>
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<tr>
<td>ATES - West Dallas Day Habilitation Classroom</td>
<td>DHC</td>
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<tr>
<td>ATES - West Dallas Day Habilitation Workshop</td>
<td>DHW</td>
<td></td>
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<tr>
<td>ATES - West Dallas Vocational Workshop</td>
<td>WDW</td>
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<tr>
<td>ATES - Young At Heart</td>
<td>YAH</td>
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<tr>
<td>Cullen - Assisted Living</td>
<td>AL</td>
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<tr>
<td>Cullen - Independent Living</td>
<td>IL</td>
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<tr>
<td>Willow River Farm - Residential</td>
<td>WRF</td>
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<tr>
<td>Willow River Farm - Assisted Living</td>
<td>WRFAL</td>
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<tr>
<td>Willow River Farm – Day Habilitation</td>
<td>WRFDH</td>
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INVOICE MAILING ADDRESS:
Street Address: ________________________________________
City: ___________________ State: _______ Zip: _________

COMMENTS: ________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Signature of Program Director/Manager     Date

Signature of Admission Coordinator       Date

Send a copy to Accounting within 5 working days prior to entry date; original submitted with Intake Checklist to Records.
The Center

ADMISSION MEDICATION HISTORY

NAME:________________________________________ DATE OF BIRTH:____________________

List any allergic reactions to medications:________________________________________________

A. CURRENT MEDICATIONS:

<table>
<thead>
<tr>
<th>Name of Medication Presently Prescribed</th>
<th>Reason for Medication</th>
<th>Date Prescribed</th>
<th>Prescribing Doctor</th>
<th>No. of Times per Day</th>
<th>How Much Medicine Each Time</th>
<th>Where is Medication Taken</th>
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B. PAST MEDICATIONS

<table>
<thead>
<tr>
<th>Name of Medication Prescribed</th>
<th>Reason for Medication</th>
<th>Date Prescribed</th>
<th>Date Discontinued</th>
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SIGNATURE:_______________________________________ DATE:______________

(Individual / Parent / Guardian)
REPORT OF PHYSICAL EXAMINATION

NAME: _______________________________ DATE OF BIRTH: _______________ M____ F____

SECTION I - Condensed Medical History:


Known Allergies:

SECTION II - Medication Presently Prescribed and Reason for Use:


SECTION III - Results of Physical Examination:

HT: _______ WT: _______ PULSE RATE: _______________ BLOOD PRESSURE: _______________

NUTRITIONAL STATUS: _______ Good ________ Fair ________ Poor - Recommendations (DIET):

EYES: _______ Normal ________ Abnormal - Comments: _________________________________

Describe ability to see: _______________________________________________________________


EARS: _______ Normal ________ Abnormal - Comments: _________________________________

Describe ability to hear: ______________________________________________________________

NOSE: _______________________________________

MOUTH: _____________________________________

THROAT & NECK: ______________________________________

BREAST: ______________________________________

THORAX & LUNGS: ______________________________________
NAME: ____________________________          DATE OF BIRTH: ______________

CIRCULATORY SYSTEM: Heart ____________________________

EXTREMITIES: ____________________________

ABDOMEN: ____________________________

HERNIAS: ____________________________

GENITO-URINARY-GYNECOLOGICAL & RECTAL: ____________________________

OSSEOUS & MUSCULAR SYSTEM: ____________________________

SKIN: ____________________________

NEUROLOGICAL: ____________________________

MENTAL STATUS: ____________________________

If on psychoactive medication, note any Side Effects and results of Assessment of Involuntary Movement:

HISTORY OF SEIZURES: _______ No _______ Yes, list type: ____________________________

If on anticonvulsant medication, comment on any side-effects noted:

DIAGNOSTIC FINDINGS AND/OR IMPRESSIONS: ____________________________

Is this person free from communicable diseases? _______ YES _______ NO - If No, Explain: ____________________________

Is this person able to attend program without restrictions? _______ YES _______ NO - If No, Specify: ____________________________

OTHER EXAMINATIONS/LABORATORY TESTS NEEDED: ____________________________

(Forward results when completed)

Physician’s Signature

FOR AGENCY USE ONLY:

Reviewed by: ____________________________

Date: ____________________________

RESIDENTS ONLY:

Full Address and Telephone Number

The above results have been explained to me.

Date of Examination

Resident’s Signature
**PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION**

Name: ____________________________  
Birth Date: _________________________  
Date: ______________________________

Diagnosis: ____________________________

Allergies: ______________________________

Reason for referral to physician: ________________________________

Diet: ______________________________

**CURRENT ORDERS:** Signature of physician indicates these orders are renewed unless discontinued in new order section below.

<table>
<thead>
<tr>
<th>Medication / Strength</th>
<th>Route</th>
<th>Directions</th>
<th>No. Units / Stop Order Date</th>
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**NEW ORDERS:** 1) Generic Equivalent approved for use on all legend and non-legend medications unless otherwise indicated. 2) Please indicate calendar-date stop order for each medication ordered. Medications for behavior management must, according to standards under which The Center operates, have a calendar date stop order of 30 days or less.

<table>
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</table>

Activity Restrictions:

**TEST RESULTS:** Please indicate any laboratory tests, x-rays, blood levels, etc. performed. You will be called for results if they are unavailable at time of this report (continue on reverse side if necessary):

Return Appointment Date / Time: _____________________________ / ________________

Physician's Signature: _____________________________  
Date: _____________________________

*(Please print or type the Physician's Name, Office Address & Telephone Number on the line below.)*

Signature of Nurse Receiving Orders (LVN/RN) _____________________________  
Date / Time _____________________________ / _____________________________

This is your permission to administer the above medications, treatments, and/or procedures as requested by physician.

Signature of Individual / Guardian: _____________________________  
Date: _____________________________
The Center  
3550 West Dallas - Houston, Texas 77019  
MAIN 713-525-8400   FAX 713-525-8493

ANNUAL TB TEST

INDIVIDUAL ___________________________ DATE ________________

DATE OF BIRTH _______________________ SOCIAL SECURITY # __________________

Annual TB skin testing is recommended for all individuals served at The Center. Please provide your primary care physician with this form to have your skin test administered and/or read. Should the results of your skin test be positive, you are required to have a chest x-ray before you may return to The Center. Also, if you are a known positive reactor, you should have a chest x-ray every two years, or as often as recommended by your primary care physician.

Know the signs and symptoms of TB, which include but are not limited to: PRODUCTIVE AND PROLONGED COUGH, COUGHING UP BLOOD, FEVER, CHILLS, LOSS OF APPETITE, WEIGHT LOSS, FATIGUE/WEAKNESS, OR NIGHT SWEATS.

( ) ANNUAL SKIN TEST   ( ) CHEST X-RAY   ( ) EXEMPT

Once the TB test and/or Chest X-Ray have been read and the results recorded on this form, please return this form to The Center / Records Department at 3550 West Dallas, Houston, Texas 77019.

LICENSED NURSING STAFF ONLY:

DATE OF TEST: ________________  Lot # ________________  Expires: ________________

SITE: LEFT _____ RIGHT _____

ADMINISTERED BY: ____________________________

DATE READ: ___________  (Results of skin test must be read 48-72 hours after the test is administered.)

RESULTS: POSITIVE _____ Millimeters  NEGATIVE _____

READ BY: ____________________________

CHEST X-RAY RESULTS (if applicable)

LICENSED STAFF ONLY:

DATE OF X-RAY: ________________  ADMINISTERED BY: ____________________________

RESULTS: POSITIVE _____  NEGATIVE _____  READ BY: ____________________________

Original: Individual Master Record