



Medical Information Release

I, (caregiver) _____, give permission to Dr. _____

to complete the Kay Senior Care Center Medical Information Report for my family member/friend.

Name: _____

Date of Birth: _____

Any additional information would be helpful, such as History, Physical and Social intake. I understand this information will be kept confidential and is required for enrollment at the Kay Senior Care Center.

Doctor's Name: _____

Phone Number: _____

Fax Number: _____

Signature: _____ Date: _____

Relationship to participant: _____

Emergency Form

Date: _____

Participant's Name: _____

Date of Birth: _____

Primary Caregiver: _____

Address: _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Drug/Food Allergies: _____

Medical Diagnosis: _____

Emergency Numbers (At least two people excluding primary caregiver)

1. Name & Relationship: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

2. Name & Relationship: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

3. Name & Relationship: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

List of individuals authorized to provide transportation _____



Do you have a Living Will? Yes ___ No ___ Power of Attorney? Yes ___ No ___

Primary Physician: _____ Telephone Number: _____

Insurance Policy: _____ Insurance #: _____

Hospital Choice #1: _____ #2: _____

I understand that in the event of an emergency, the Kay Senior Care Center Staff will contact myself or those listed. Should the emergency be serious and my family member needed immediate treatment, he/she will be transported to the hospital of my choice, if possible. I also understand that I am responsible for any cost of transportation or medical treatment my family member receives. My signature indicates my permission for my family member to be treated in an emergency situation.

To be in compliance with the Tennessee Department of Human Services, I understand if my family member has a Living Will or Power of Attorney, I must submit a copy to the Kay Senior Care Center to keep on file.

Caregiver's Signature: _____ Date: _____



Medication Form

Date: _____

Participant's Name: _____

Date of Birth: _____

Please list ALL prescribed and non-prescribed medications

	Medication Name	Reason Prescribed	Dosage/Time	Prescribing Physician
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

It is my responsibility to provide the Kay Center with a complete list of ALL prescribed and non-prescribed medications. If medications are changed, I will alert the Kay Center staff and complete a new Medication Form.

If medications are to be taken at the Kay Center, a medication instruction form must be completed. Without this form, the Kay Center staff will not be able to provide medication assistance.

Signature of participant or POA for Health Care

Date



Getting To Know You

Participant's Name _____ Name Preferred _____

Date of Birth _____ Birth Place _____

Primary Caregiver _____

Spouse _____

Children (Name, Where they Live, Their Children) _____

Major Life Events _____

Schools Attended/Areas of Study _____

Occupation _____

Groups/Organizations/Religious Involvement _____

Hobbies/Talents (past and present): _____

Current Activities _____

Food Likes: _____ Food Dislikes: _____

Special Needs: _____

Describe how your loved one spends a typical day: _____

What can we do to make your loved one comfortable at the center? _____

