



# LEGACY HOUSE

## Inquiry Form

Today's Date: \_\_\_\_\_

Assisted Living     Adult Day Health     Adult Day Care

Applicant Name:	Contact Name:
Applicant Phone #:	Contact Phone #:
Applicant Address:	Contact Address:
Primary Language:	Relation to Applicant:

Date of Birth/Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status:
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, PIC Number: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Number: _____ SSN: _____	
Present living situation:	<input type="checkbox"/> Living alone	<input type="checkbox"/> Living with _____
<input type="checkbox"/> House	<input type="checkbox"/> Apartment	<input type="checkbox"/> Retirement Home
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Other:	

Who is your primary physician? Name: _____ Phone: _____ Fax: _____	
Who is your DSHS SSW? Name: _____ Phone: _____ Fax: _____	
Why do you need our services at this time?	
What are your health concerns?	
How did you hear about Legacy House?	<input type="checkbox"/> Friend <input type="checkbox"/> ACRS <input type="checkbox"/> Advertisement <input type="checkbox"/> Medical Professional
	<input type="checkbox"/> Family <input type="checkbox"/> CISC <input type="checkbox"/> Phone Book <input type="checkbox"/> Other:



LEGACY HOUSE  
INTERNATIONAL DISTRICT  
VILLAGE SQUARE

**RELEASE OF PROTECTED HEALTH INFORMATION  
TO LEGACY HOUSE**

I, \_\_\_\_\_, authorize the release of health, psychosocial and financial information from the State/Community Case Manager for review by staff at Legacy House for evaluation prior to move in/admission to Legacy House or Legacy House Programs.

\_\_\_\_\_  
Signature of client/resident

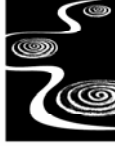
\_\_\_\_\_  
Date

or

\_\_\_\_\_  
Signature of client/resident legally responsible arty

\_\_\_\_\_  
Date

**Legacy House  
803 South Lane Street  
Seattle, WA 98104  
(206) 292-5184 ph  
(206) 292-5271 fax**



LEGACY HOUSE  
INTERNATIONAL DISTRICT  
VILLAGE SQUARE

**RELEASE OF PROTECTED HEALTH INFORMATION  
TO LEGACY HOUSE**

I, \_\_\_\_\_, authorize the release of medical information from my Health Care Provider for review by staff at Legacy House for evaluation prior to move-in/admission to Legacy House or LH programs.

\_\_\_\_\_  
Signature of client/resident

\_\_\_\_\_  
Date

or

\_\_\_\_\_  
Signature of client/resident legally responsible party

\_\_\_\_\_  
Date

**Legacy House  
803 South Lane Street  
Seattle, WA 98104  
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LEGACY HOUSE

# ADULT DAY SERVICES PROGRAM

## Physician's Order Form

803 SOUTH LANE STREET, SEATTLE, WA 98104-3031  
▪ (206) 292-5184 ▪ FAX: (206)292-5271

Today's Date:

Please return by:

Physician Name:		Phone:	Fax:
Client Name:	Client DOB:	Client SSN:	

Your client is being considered for our Adult Day Services program. **Washington State Day Health Law requires that our program obtain a signed physician order to provide skilled nursing and therapeutic activities as well as the following information.** Please take the time to fill out this form for the client and return as soon as possible, our fax number is listed above.

Date of last office visit:	Date of last complete exam:	Approximate Weight:	Height:
Last set of vital signs:		How often do you want to see this client?	
<b>Diagnosis:</b> Health Problems	<b>Medications:</b> (include dose, route, and frequency include prns for pain, indigestion)		
<b>Allergies:</b> (food/medication/other)	May a Nurse administer these medications on site if needed? <b>YES NO</b>	May a Nurse give the flu vaccine annually? <b>YES NO</b>	

<b>Please check all skilled nursing recommendations and indicate frequency next to it:</b>			
<input type="checkbox"/> Occupational Therapy _____x/week	<input type="checkbox"/> Medication Administration _____x/week	<input type="checkbox"/> Catheter irrigation _____x/week	<input type="checkbox"/> Dry wound care _____x/week
<input type="checkbox"/> Observation & Assessment _____x/week	<input type="checkbox"/> Teaching & training _____x/week	<input type="checkbox"/> ADL Management _____x/week	<input type="checkbox"/> Other (please indicate)

<b>Activity:</b> An OT is available to evaluate your client for functional strength, flexibility, balance and mobility. Please indicate your concern if you have regarding this client:	<b>Resuscitation:</b> <ul style="list-style-type: none"> <li>Do you have a <b>Resuscitation Preference</b> while your client is at our Adult Day Health program? <b>YES NO</b></li> <li>If YES: <b>FULL CODE NO CODE</b></li> <li>Have you signed an EMS/ NO CPR form with the client? <b>YES NO</b> (If YES, please attach)</li> </ul>
Please indicate below if client has <b>Elopement Risk: YES NO</b>	Does client have record of <b>TD immunization: YES NO</b>

<b>Adult Day Health Program REQUIRES a 2 step PPD:</b>			
Does client have record of PPD? <b>YES NO</b>	If it was positive, was Chest X-ray done? <b>YES NO</b>	If you have no PPD record, may Legacy House staff administer PPD? <b>YES NO</b>	If no, will you? <b>YES NO</b>
Date:	Date:		
Result:	Result:		

\_\_\_\_\_  
Prescribing Practitioner Signature

\_\_\_\_\_  
Date

