Pre-Enrollment

8826 Woodstock Road, Quechee, VT 05059

PO Box 180, Woodstock, VT 05091

Phone: (802) 280-6080

Fax: (802) 280-6079

info@scotlandhousevt.org

Participant Check List

Thank you for your interest in spending time at The Scotland House in our Health and Wellness Program! We are looking forward to spending time with you. As with all programs, there is paperwork to complete. Here is a list of what your family/caregiver can complete independently. Other documents that require Scotland House staff assistance, will be completed prior to your first day with us.

Have I remembered to…

- ☐ Have the **Physicians Review Form** completed and signed by your primary care physician.
- ☐ Send or bring the required documents listed on the Physicians Review Form.
- ☐ Filled out all of the **Personal and Emergency Contact Information** form**.**
- ☐ Filled out all of the **Scheduling Information** form.
- ☐ Filled out all of the **Personal Care Information** form.
- ☐ Filled out all of the **Dietary Information** form.
- ☐ Filled out all of the **Life History** form.
- ☐ Signed **Photo and Media Release**.
- ☐ Filled out all of the **Non-Clinical Contact Information**
- ☐ Filled out all of the **Authorization for Release of Medical Records**
- ☐ Send or bring copy of your:
    - Advanced Directive and/or Living Will;
    - Do Not Resuscitate Order Form (DNR);
    - Clinicians Order for Life Sustaining Treatment Form (COLST)
- ☐ Send or bring a copy of Guardianship or an activated Durable Power of Attorney (DPOA) paperwork if pertinent.
- ☐ Send or bring a copy of Social Security, Medicare, Medicaid, V.A., and/or insurance cards (any that you would present upon hospital admission) to be kept on file. If needed, we will be happy to make a copy.
- ☐ Send or bring a copy of your COVID-19 Vaccination Card

These forms MUST be completed and returned to The Scotland House as part of your admission to the program. Our staff is here to help you in any way. Please do not hesitate to call or email us with any questions.

In addition to all the required paperwork, we ask that you also bring for your loved one:

- ☐ A complete change of clothing (pants, shirt, underwear, socks, etc.) that can be left here for emergencies. Please be sure participant name is written on each item.
- ☐ Any type of protective undergarment (adult briefs, pads, etc.) your love one may use.
- ☐ Any personal care items such as toothpaste, toothbrush, shampoo, deodorant, etc.
- ☐ If we are to give any prescription or non-prescription medications during the day, we require that the medications be in their original containers. For prescription medications pharmacies are very willing to give a second bottle with the prescription on it if you only ask.

Physician Review

Participant Name: _____ Date of Birth: _____

In order for a participant to attend our program, all pertinent medical information listed below must be received by the Scotland House and this form signed by their physician prior to their first day.

***** All participants must be able to assist with a one person transfer and must be able to assist with feeding themselves. *****

Please supply all the following medical information:

- ☐ Copy of most recent History and Physical including the Problem list.
- ☐ Copy of Immunization Record including tetanus and flu vaccine information.
- ☐ Current Allergy List.
- ☐ Current Medication List (medications, vitamins and supplements).
  - A written physician order is required if medications will be dispensed at The Scotland house.
- ☐ Copy of Physician Orders for Treatments.
- ☐ Current Dietary Needs.

Information can be sent via:

- **Fax: 1 (802) 280-6079**
- **Mailing Address: PO Box 180, Woodstock, VT 05091**

Question and Review

(Please answer each question.)

Able to participate in light exercise? (seated chair exercises)	YES	NO
Take Tylenol PRN for pain or fever? (Two 325 mg tablets at 4-hour intervals)	YES	NO
Take Benadryl PRN for allergic reaction? (Take 1-2 25 mg tablets a 4-6 hour intervals)	YES	NO
Take Imodium PRN for diarrhea? (2mg A+D caplets)	YES	NO
Take Tums PRN for upset stomach? (1-2 at 2-hour intervals, up to 8 tablets daily)	YES	NO
Has your patient been hospitalized within the last three (3) months? If yes, please include discharge summary.	YES	NO

Physician Signature: _____ Date: _____

THE Scotland House
We Share the Care
ADULT DAY CARE AND WELLNESS

Personal and Emergency Contact Information

Participant's Full Name: (First, Middle, Last) _____

Physical Address: (Address, City/Town, State, Zip Code) _____

Mailing Address: (If different then physical address) _____

Home Phone Number: _____ **Alternate Phone Number:** _____

Social Security Number: _____ - _____ - _____ **Date of Birth:** (Month, Day, Year) _____ / _____ / _____

Marital Status: _____ **Name of Spouse/Partner:** _____

Primary Physician: _____ **Hospital Location:** _____

Preferred Hospital in the Case of an Emergency: _____

Allergies: _____

Emergency Contact Information: (Please list in priority of who to contact first.)

Emergency Contact 1: _____

Relationship: _____ **Email:** _____

Phone Number: _____ **Alternate Phone Number:** _____

Mailing Address: _____

Emergency Contact 2: _____

Relationship: _____ **Email:** _____

Phone Number: _____ **Alternate Phone Number:** _____

Mailing Address: _____

Advanced Directive for Health Care: ☐ Yes ☐ No

If yes, has it been activated by a physician? ☐ Yes ☐ No

Name of activated DPOAH: _____

Legal Guardian? _____

Do you have a DNR Order? (Do Not Resuscitate)
☐ Yes ☐ No

Do you have a COLST? (Clinicians Order for Life Sustaining Treatment)
☐ Yes ☐ No

****PLEASE PROVIDE A COPY OF YOUR ADVANCED DIRECTIVE, DNR, AND/OR COLST FORM****

Scotland House Use Only:

Attach Photo Here

Scheduling Information

Participant Name: _____ Date of Birth: _____

Desired Start Date: _____

Desired Days and Time of the Week:

☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
Arrive: _____	Arrive: _____	Arrive: _____	Arrive: _____	Arrive: _____
Depart: _____	Depart: _____	Depart: _____	Depart: _____	Depart: _____

Payment:

☐ Private Pay ☐ VT/NH/MA Medicaid ☐ VA ☐ Grant

Transportation:

☐ Family ☐ Caregiver

Fees for Service

The Scotland House fee for service is $21.00 per hour which includes all The Scotland House services. The minimum requirement for a participant is 4 hours per day and at least two days per week is required. Schedule may vary on a case by case basis.

All fee's and minimum requirements are subject to change as deemed appropriate by The Scotland House.

Personal Care Information

Participant Name: _____ Date of Birth: _____

We have all led very independent lives and the staff at The Scotland House recognizes that it is hard to allow someone else provide personal care for you. Our goal is to help you to stay as independent, and at home for as long as possible. Assisting you with personal care is just one way we can accomplish your goals together. As you may have personal preference for products (shampoo, deodorant, toothpaste, soap, etc.), we ask that you supply your own personal care products to remain at The Scotland House for your individual use.

Who typically helps you with personal care?

☐ Independent ☐ Family ☐ Spouse ☐ Caregiver ☐ VNA

☐ Other: _____

Bathing:

At The Scotland House we can assist you with taking a shower in our spa.

Would you like to have a shower during your time at The Scotland House? ☐ Yes ☐ No

If yes, please answer the following:

Do you have a fear of water? ☐ Yes ☐ No

Do you enjoy having a shower? ☐ Yes ☐ No

Do you enjoy having your hair washed? ☐ Yes ☐ No

Do you get very cold after you bathe? ☐ Yes ☐ No

Do you prefer cool water or very warm water when bathing? ☐ Yes ☐ No

Do you have a bathing routine we should know about? (having a snack/beverage afterwards, having your hair styled, face shaved, using perfume or aftershave) ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you have any concerns with your skin or nails that staff should know about? ☐ Yes ☐ No

If yes, please explain: _____

_____

Oral Hygiene:

Would you like someone to assist you or remind you to brush your teeth after lunch? ☐ Yes ☐ No

If yes, do you enjoy brushing your teeth? ☐ Yes ☐ No

Do you brush your teeth independently or do you like to have some help? _____

_____

Personal Care Information Continued...

Incontinence:

As we age our bladder's and bowels can take on a mind of their own. It is very helpful to know if we can support you with incontinence care.

Do you have Urinary Incontinence? ☐ Yes ☐ No

Do you have Bowel Incontinence? ☐ Yes ☐ No

Do you take medication for incontinence? ☐ Yes ☐ No

Do you use incontinence products? ☐ Yes ☐ No

If yes, what products do you use? _____

_____

Is there anything that you find helpful to manage it? (Going to the bathroom every 2-3 hours, etc.)

_____

_____

Nail Care:

Are you interested in getting fingernail care? ☐ Yes ☐ No

Are you interested in getting foot nail care? ☐ Yes ☐ No

Dietary Information

Participant Name: _____ Date of Birth: _____

At the Scotland House we provide two snacks, lunch, and beverages throughout the day. Our delicious and healthy lunch is provided by the Thompson Center in Woodstock, VT. There may be times that you do not like what our lunch is for the day, in that case we are happy to offer you and alternative if you choose. Alternatives may vary from day to day. Please complete the questions below to help us better serve you.

List Foods You Enjoy:

_____

_____

_____

_____

List Beverages You Enjoy:

_____

_____

_____

_____

List Foods You Dislike:

_____

_____

_____

_____

List Beverages You Dislike:

_____

_____

_____

_____

Do you have any dietary restrictions and/or food allergies? (Lactose Intolerant, Egg allergy, peanut allergy, etc.)

_____

_____

Do you have a need for adaptive eating utensils? ☐ Yes ☐ No

If yes, what type? (Brand, where to buy, picture – helpful for us to know)

_____

Do you need adaptive drinking cup? ☐ Yes ☐ No

Do you need thickened liquids? ☐ Yes ☐ No

If yes, what type of thickened liquids? (Nectar, Honey, Pudding) _____

Do you have a need for your food to be in a different texture other than a regular diet?

☐ Soft Food ☐ Chopped (Meat) ☐ Cut Up ☐ Puree

What type of diet do you try to follow?

☐ Regular No Added Salt ☐ Vegetarian ☐ Gluten Free

☐ Sugar Free ☐ Other: _____

Life History

Participant Name: _____ Date of Birth: _____

Do you have a nickname you go by? _____

Living Arrangements?	☐ Independently	☐ Caregiver	☐ Spouse	☐ Family
Mobility?	☐ Independent	☐ Walker	☐ Cane	☐ Wheelchair
Do you wear hearing aids?			☐ Yes	☐ No
Do you wear glasses?			☐ Yes	☐ No

Where were you born? _____

Other than English, do you speak another language? _____

What is the highest level of education you accomplished? _____

Who are the special people in your life? (Please include their name and relationship to you.)

_____

_____

At The Scotland House we celebrate and value diversity. What is/has been important to you and your lifestyle? (religion, roles of men and woman, traditional beliefs, etc.)

_____

_____

_____

Dates, traditions, and special occasions that are important to you? (Holiday's, anniversaries, etc)

_____

_____

_____

Are you a Veteran? ☐ Yes ☐ No

If yes, What branch of the service? _____

Where were you deployed to? _____

Do you like to travel? ☐ Yes ☐ No

If yes, where have you been? _____

Do you like animals? ☐ Yes ☐ No

If yes, what type of animals do you like? _____

Do you have a fear of animals? ☐ Yes ☐ No

How do you currently spend your day?

_____

_____

_____

Life History Continued…

What are your current hobbies/interest?

Games:
Bingo
Checkers
Chess
Dominoes
Monopoly
Scrabble
Yahtzee
_____
_____

Crafts:
Ceramics
Crocheting
Knitting
Scrapbooking
Stained Glass
Woodworking
Quilting
_____
_____

Pets:
Dog
Cat
Bird
Fish

Cards:
Canasta
Uno
Phase 10
Skip Bo
Solitaire
Rummy
Poker
Bridge
_____
_____

Music:
Classical
Country
Gospel
Jazz
Big Band
30's and 40's
50's and 60's
Rhythm
Rock and Roll
Heavy Metal
Easy
Listening
_____
_____

Exercise:
Stretching
Walking
Yoga
Tai Chi
Aerobic
_____
_____

Gardening:
Flowers
Vegetables
Shrubs
House Plants
Cactus
_____
_____

Household:
Cleaning
Laundry
Dish Washing
Cooking
Baking
Decorating
_____
_____

Puzzles:
Crossword
Word Search
Word Scramble
Jigsaw
_____
_____

Sports:
Baseball
Basketball
Football
Bowling
Fishing
Hunting
Hockey
Horseshoes
Ring Toss
Volley Ball
Horse Racing
Soccer
_____
_____

Computer:
Games
Internet

Art:
Oil Painting
Sculpture
Watercolors
Drawing
Chalks
Clay
Coloring
_____
_____

Reading:
Historical
Nonfiction
Fiction
Religious
Westerns
Mystery
Newspaper
Poetry
Romance
Magazines
Bible
Comics
_____
_____

Movies:
Comedy
Drama
Musical
Westerns
War
Sci-fi
40's and 50's
_____
_____

Instruments:
Piano
Guitar
Saxophone
Tambourine
Cow Bell
Trumpet
_____
_____

Writing:
Poetry
Letters
Short Stories
_____
_____

Just for Fun:
Parties
Picnics
Tea Time
Plays
_____
_____

Other:
Travel
Dancing
Genealogy
Collecting:
_____
Automotive
Nail Care
Hairdresser
Barber
_____
_____

May we invite family and friends to facility functions:
Yes / No

What are some of your past hobbies and interest?

_____
_____
_____

What are the most important things you would like staff at The Scotland House to know about you?

_____
_____
_____

This information is very important as we get to know you. Thank you for taking the time to share it with us!

Photo and Media Release

Participant Name: _____ Date of Birth: _____

- ☐ I give my permission for The Scotland House to take my picture for medical and safety reasons as part of my medical record.

- ☐ I give my permission for The Scotland House to take my picture during programs and activities to use within The Scotland House program only.

- ☐ I give my permission for The Scotland House to take my picture and/or use statements I have made for publicity/marketing purposes. All marketing purposes have the intent to promote awareness and concern for older adults and the need for Adult Day Health and Wellness. (Brochure, Facebook, Webpage, newspaper article, newsletter, etc.)

- ☐ I give my permission for my family members first and last name to be published in any publicity/marketing purposes.

- ☐ I give my permission for my family members first name only to be published in any publicity/marketing purposes.

Signature of Participant or Representative: _____ Date: _____

Participant or Representative Name (Printed): _____

Relationship to Participant (if requester is not participant): _____

Staff/Witness Signature: _____ Date: _____

Staff/Witness Name (Printed): _____

Non-Clinical Contact Information

The Scotland House periodically sends out updates, monthly newsletters, and other informative information. We are happy to share this non-clinical information with more than the primary caregiver (children, siblings, etc.). If you have someone who would enjoy this form of communication, please provide the following information below.

FIRST CONTACT:

Name: _____ Email: _____

Address: (Address, City/Town, State, and Zip Code)

_____

Would you like to receive The Scotland House Newsletter? ☐ Yes ☐ No

If yes, how would you like to receive it? ☐ Mail ☐ Electronically

SECOND CONTACT:

Name: _____ Email: _____

Address: (Address, City/Town, State, and Zip Code)

_____

Would you like to receive The Scotland House Newsletter? ☐ Yes ☐ No

If yes, how would you like to receive it? ☐ Mail ☐ Electronically

☐ ☐

THIRD CONTACT:

Name: _____ Email: _____

Address: (Address, City/Town, State, and Zip Code)

_____

Would you like to receive The Scotland House Newsletter? ☐ Yes ☐ No

If yes, how would you like to receive it? ☐ Mail ☐ Electronically

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Participant Name: _____ Date of Birth: _____

Address: _____

City, State, and Zip: _____

Social Security Number: _____ Patients Phone Number: _____

Date of Request: _____ Date Needed: _____

☐ I authorize Woodstock Area Adult Day Services, Inc d/b/a The Scotland House to obtain medical information from:

Provider Name: _____

Facility: _____

Address: _____

City, State, and Zip Code: _____

Phone Number: _____ Fax Number: _____

TYPES OF RECORDS REQUESTED:

☐ History / Physical / Problem List
☐ Dietary Needs
☐ Medication List
Including: Written Physician Order if Medication is being dispensed at the Scotland House.

☐ Allergy List
☐ Physician Orders for Treatments
☐ Immunization Record
Including: Tetanus and Flu Shot Information

AUTHORIZATION VALID FOR: (check one)

☐ This request only.

☐ One year from the date of this authorization OR _____. (Insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any **future** treatment of the type described above until _____. (insert date)

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care will not be affected if I do not sign this form. If I change my mind, I understand I can revoke this authorization by providing a written notice to The Scotland House at the address written below. The revocation will be effective immediately upon receipt of my written notice.

Signature of Participant or Representative: _____ Date: _____

Relationship to Participant (if requester is not participant): _____

PO Box 180 Woodstock, VT 05091 Phone: (802) 280-6080 Fax: (802) 280-6079

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Woodstock Area Adult Day Services, Inc. d/b/a The Scotland House.