ADP Application

To provide a safe and effective program, it is necessary for all perspective clients of the Adult Day Program (ADP) to complete this application. All information provided will remain confidential, *pages 6-9 are for your physician*. If the client is unable to complete independently a parent, guardian, or power of attorney must sign the application. Please return to Neuro Vitality Center.

2800 East Alejo Road, Palm Springs, CA 92262-6253
760-323-7676, info@NeuroVitalityCenter.org

Clients Personal Information:

First Name, Last Name: ____________________________________ Date of Birth: ___/___/_____

Home Phone: (_______) ____________________ Cell Phone:(_______) ______________________

Address: ____

City: ____ State: __________ Zip Code: _____________

E-Mail: ____

Emergency Contact Name: ____

Emergency Contact Phone: (_______) ____________________ Relationship: ______________

Date of Injury, if any: ___/___/_____ Type of Disability, if any: __________________________

Caregiver's Name: _____________________ Contact Phone: ______________________________

Medicare #: ____________________ Medi-Cal #: _________________ Issue date: ___/___/_____

Previous Rehabilitation: _____________________________________ How long: _____________

Benefits of Rehab: ____

____

List any concerns you may have that we should be aware of regarding participation in exercises and activities, i.e., limitations in range of motion, endurance levels, and/or experience in training. This information will assist us in advising you and accomplishing your goals:

____

____

____

____

ADP Application

Please list any specific goals and/or expectations you are seeking:

____
____
____
____

Medical history Information

Height:	Weight:	Gender: MALE / FEMALE
Physician Name:		Physician Address:
Physician Phone:		
Physician Specialty:		Physician E-Mail:
Wheelchair: YES / NO	If YES: Electric / Power or Push Assist / Manual	
Assistive Devices: YES / NO		If YES describe:
Current Therapies: YES / NO		If YES describe:

Check yes/no, indicate yes for all that apply at present or have applied in the past.		
General Health	YES	NO
History of chest pain	☐	☐
History of heart disease or any heart/valve disorder	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Difficulty with physical exercise/activity	☐	☐
History of pathological fracture	☐	☐
Pregnancy (now or in last 3 months)	☐	☐
Breathing/lung problems (Asthma)	☐	☐
Any other disease of lungs	☐	☐
Muscle, joints, or back disorder	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
High cholesterol	☐	☐
Obesity	☐	☐

ADP Application

General Health - Continued	YES	NO
Hernia, or any condition that may be aggravated by exercise	☐	☐
Osteoporosis or Osteopenia	☐	☐
Contractures limiting range of motion	☐	☐
Heterotrophic ossification	☐	☐
Seizure or Epilepsy	☐	☐
Lightheadedness or fainting	☐	☐
Pressure sore or skin breakdown	☐	☐
Deep vein thrombosis (DVT)	☐	☐
CVA or stroke	☐	☐
Traumatic brain injury	☐	☐
Spasm or spasticity:	☐	☐
Tone	☐	☐
Pain (general)	☐	☐
Pain (neuropathy)	☐	☐
Autonomic Hyperreflexia, or Autonomic Dysreflexia (AD)	☐	☐
Rods, plates, cages	☐	☐

CARE AND MEDICATION	**YES**	**NO**
Are you currently under a physician's care?	☐	☐
If yes, describe:		
Have you been hospitalized in the last 12 months?	☐	☐
If yes, describe:		

MEDICATION: Please list all medications you are currently taking.

MEDICATION	**DOSAGE/DAY**	**REASON**

ADP Application

MEDICATION	DOSAGE/DAY	REASON

Honorable Agreement

I, ______________________________ (Print Clients Name) have read and completed this application truthfully, and to the best of my knowledge. I realize that it is in my best interest to complete these forms honestly. I understand that I need to include any illnesses, disorders, or health issues that may not be included on these forms. I will take full responsibility for any false responses to any of the questions in these forms, and do not hold it to Neuro Vitality Center or its staff to be liable.

____
Signature of Participation

____
Signature of Witness or Power of Attorney

____
Date

____
Date

____
Parent/Guardian Signature
(If under 18 years old, Parent/Guardian must also sign)

____
Date

The information in this application is confidential and is protected under the HIPAA Privacy Act. This information is used solely by the staff of Neuro Vitality Center in determining program eligibility and participation.

ADP Application

Participant Waiver and Release of Liability Form

I, ____, HEREBY ASSUME ALL RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH Neuro Vitality Center, ITS EMPLOYEES, AND VOLUNTEERS. Including by way of example, but not limitation, any risks that may arise from ODINARY NEGLIGENCE OR CARELESSNESS on the part of the Neuro Vitality Center its employees or volunteers, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability, which may arise during normal exercise and therapeutic activities at the Neuro Vitality Center.

I HEREBY CERTIFY that I am physically fit, have sufficiently prepared or trained for participation in this activity, and have not been advised to not participate by a qualified medical professional. I certify that there are no current health-related reasons or problems, which preclude my participation in this activity. I further acknowledge that I will only participate in activities at the Neuro Vitality Center with which I am comfortable and pose no medical risk as known to me.

In consideration of my application and permitting me to participate in this activity, I hereby act for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:
(A) I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the ordinary negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity, THE FOLLOWING ENTITIES OR PERSONS: The Neuro Vitality Center and/or their directors, officers, employees, volunteers, representatives, and agents. I acknowledge that the Neuro Vitality Center and their directors, officers, volunteers, representatives, and agents are NOT responsible for the errors, omissions, acts, or failures to act of any party or entity conducting a specific activity on their behalf;
(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in the above paragraph from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise. All injuries associated with participation in activities at Neuro Vitality Center are hereby covered by this Participant Waiver and Release of Liability Form.

I hereby understand the Neuro Vitality Center is not a medical treatment facility, but consent to receive medical treatment in the event of injury, accident, and/or illness during the activity which Neuro Vitality Center or its employees may deem necessary to administer in their own judgment. I hereby release all claims associated with the medical treatment, or lack thereof, which Neuro Vitality Center or its employees may administer.

I acknowledge that this Participant Waiver and Release of Liability Form will be used by the program holders, sponsors, and organizers of the activities in which I may participate, and that it will govern my actions and responsibilities during said activities. This Participant Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under Colorado law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT THAT I SIGN OF MY OWN FREE WILL.

______________________________	______________________________
Signature of Participation	Signature of Program Director/Witness
______________________________	______________________________
Date	Date
______________________________	______________________________
Parent/Guardian Signature (If under 18 years old, Parent/Guardian must also sign)	Date

ADP Application

Physician Release Form

The following pages 6-9 must be presented to the participants physician prior to in-person participation at Neuro Vitality Center

Dear Physician,

Your patient, ______________________________________, is interested in participating in an adult day program at Neuro Vitality Center, the goals of which are to improve muscular strength, balance, flexibility and functionality. Neuro Vitality Center offers one-on-one exercise and group exercise programs that may include physical activity consisting of cardiovascular exercise, strength training, weight-bearing activities, flexibility training, gait training, vibration training, nutrition consultation, and arobic activities.

We are enclosing a statement of medical clearance for exercise and request that you indicate your patient's eligibility for this program. Please be sure to include any specific exercise recommendations or adaptations to address your patient's needs, and any pre-existing exercise or rehabilitative guidelines or protocols that have been established. Finally, it would be helpful if you would identify the signs or symptoms of any unstable phases of the patient's medical condition that you feel would make exercise unsafe.

If you have any questions or recommendations regarding this exercise program or your patient's participation, please contact Dr. Jay Seller (Direct Line 760-237-8903). Thank you for assisting in establishing a healthier lifestyle for your patient. We know you are busy and appreciate your time and effort in this matter.

Sincerely,

Jay Seller

Dr. Jay Seller
Exeuctive Director

In accordance with the Health Insurance Portability and Acountability Act, I hereby give my permission for the release of any information that my physician deems necessary to help with the establishment of a personalized exercise and activity program at Neuro Vitality Center.

Participant's Signature: ____ Date: ______________

ADP Application

Physicians History and Physical Form

Patient's name: ____________________________ Date: ___________

Diagnosis:

Diagnosis	ICD-10	Diagnosis	ICD-10

Medications (please indicate - dosage, frequency and indication):

Medication	Dosage	Frequency	Indication

Allergies:

Prognosis:

ADP Application

Tuberculosis Screening – Required per COVID regulations by the State of California

PPD Test	Date given:	Date read:	Results: ☐ Positive ☐ Negative
Chest X-Ray	Date given:	Date read:	Results: ☐ Positive ☐ Negative

Current Medical Exam

Cardiovascular:	Gastrointestinal:
Musculoskeletal:	Rectal:
Mouth/Throat:	Endocrine:
Respiratory:	Genitourinary:
Integumentary:	Eyes:
Nose:	Ears:
Psychological:	Incontinence: ☐ Bladder ☐ Bowel ☐ None
Hx. Seizures: ☐ Yes ☐ No	Hx. falls: ☐ Yes ☐ No
Any indication of communicable disease: ☐ Yes ☐ No Explain:	

Assistive Equipment Used:

☐ NONE USED ☐ FWW ☐ Quad Cane ☐ Single point cane ☐ Wheel chair ☐ Other:

Significant Medical History (past hospitalizations, recent surgeries, etc.):

May we have PRN orders for: (Please Check off)

Acetaminophen 500 mg. 1- or 2-tabs PO Q 3-4 hrs. PRN pain	☐Y	☐N
Ibuprofen 200-400 Mg PO Q 4 hrs. PRN pain	☐Y	☐N
Mylanta 30 cc PO q4h prn gastric discomfort	☐Y	☐N
Kaopectate 4-8 tabs PO Q 4 hrs. PRN gastric Discomfort	☐Y	☐N
02 2-3 L via nasal cannula PRN acute SOB	☐Y	☐N
NTG 0.4mg SL PRN chest pain (1dose per 3 min x 3 doses, then 911 w/no relief)	☐Y	☐N
Topical antibiotic ointment PRN superficial abrasions	☐Y	☐N

NeuroVitalityCenter

Formerly the Stroke Recovery Center

ADP Application

Diet and Nutrition:

☐ Cardiac Diet (Low Sodium, Low Fat/Low Cholesterol)

☐ Diabetic/NCS ☐ Renal ☐ Regular ☐ Other:

Medication Authorization

☐ Patient is able to administer own medication safely

☐ Qualified professional to administer medications at center

Vital Sign Notification

Our Nurse will monitor your patient's vitals, please indicate ranges that you wish to be notified:

☐ Blood pressure < - >

☐ Blood Glucose < - > ☐ Daily ☐ Weekly ☐ Other:

☐ A1C

Transportation

We endeavor to have participant transportation needs to and from the center for one hour or less. However, in order to provide regular and timely services a participant may be in a vehicle for a longer period of time. Are there any precautions or concerns we should be aware of?

☐ Yes ☐ No

Authorization of services to be provided by the Center:

☐ Agree to this request for participation in Neuro Vitality Center's services.

Please list any restrictions (if applicable):

Physician Signature:	
Physician's full Name:	
License Number:	
Phone:	Fax:
Full mailing address:	