STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES - DIVISION OF DEVELOPMENTAL DISABILITIES

Medical Form for Adults

Name: _____ Age: _____ DOB: _____ { } Male { } Female

Health Insurance #: _____ SS#: _____ Exam Date: _____

A. HISTORY:

1) Indicate any present and past medical condition (include communicable disease history):
_____
_____
_____
2) Previous hospitalizations/surgery: _____
_____
_____
3) Immunizations:

Adult Diphtheria/Tetanus-Date: _____
(Document date of last booster OR administer if more than 10 years ago.)
Hepatitis B Immunization (if given) Date: [1] _____ [2] _____ [3] _____

B. LABORATORY TESTS:

1) Mantoux Test yearly if non-reactor or chest x-ray if indicated. Past or current results must be documented:
Results: _____ Date: _____
Tine test is not acceptable. Positive Mantoux reactor should never be retested.
2) Hepatitis B Profile: Initial (repeat at physician's discretion).
Results: _____ Date: _____
(Past or current results must be documented).
3) Lead Poisoning: Blood Lead Level is required:

a. For Individuals with known Pica behavior, test annually, or according to guidelines for elevated lead levels
b. Prior to discharge from development center (within 3 months of discharge).
c. For all new admissions to Divisional residential services (within 3 months prior to admission or within 10 days after admission).
Blood Level: _____ Date: _____

4) SMAC, initial (repeat at physician's discretion): _____
5) Complete Blood Count, initial (repeat at physician's discretion): _____
6) Urinalysis, initial (repeat at physician's discretion): _____
7) Serology, initial (repeat at physician's discretion): _____
8) Pap Smear (follow American Cancer Society guidelines): _____
9) EKG – initial at age 40 (repeat at physician's discretion): _____

C. OTHER MEDICAL CONDITIONS/NEEDS:

1) Seizures: { } Yes { } No Frequency & Type, if known: _____

2) Special Dietary Needs: { } Yes { } No (Attach Prescription): _____
_____
3) Allergies, Sensitivities: (foods, drugs, others): _____
_____
4) Mental Health Problems (Behavioral/Psychiatric Disorders): _____
_____

D. MEDICATION:

Name: _____ Dosage: _____ Frequency: _____ Indication:_____

Name: _____ Dosage: _____ Frequency: _____ Indication:_____

Name: _____ Dosage: _____ Frequency: _____ Indication:_____

Name: _____ Dosage: _____ Frequency: _____ Indication:_____

Name: _____ Dosage: _____ Frequency: _____ Indication:_____

E. CLINICAL EXAMINATION:

1) Height: _____ Weight: _____ Temp.: _____ Pulse: _____ B.P.: _____

2) Sensory (Indicate any impairment and extent):

Eyes: Vision (Glasses, etc.): _____

Hearing: (Aids, etc.): _____

3) ENT: _____

4) Teeth & Gums: _____

5) Neck: _____

6) Breast (Follow American Cancer Society Guidelines for Mammography): _____
_____

7) Lymphatic System: _____

8) Respiratory System: _____

9) Cardiovascular System: _____

10) Gastrointestinal System (Stool for occult blood after age 50): _____

11) Genitourinary System: _____

12) Prostate: _____

13) Muscular System: _____

14) Skeletal System: _____

15) Neurological System:

ADDITIONAL INFORMATION/RECOMMENDATIONS:
(Please indicate if there are limitations or restrictions regarding physical activities)

_____
_____

PLEASE ISSUE PRESCRIPTIONS FOR MEDICATION, DIET, ADAPTIVE EQUIPMENT, PROCEDURES AND THERAPIES. (Please Print or Type CLEARLY)
Physician's Name: _____ Date: _____

Address: _____ Phone #:_____

Physician's Signature: _____

PLEASE RETURN COMPLETED FORM TO:

NAME:

ADDRESS: CITY: STATE: ZIP:

Form#2

Transportation Sign-Off Form

Name of Individual _____

Please sign the applicable box, read sign and return to your adult day services program as soon as possible.

Drop off Guidelines- For above named individual:

1. ☐ Can be dropped off from the vehicle and go into home even if no one is there to receive him/her.
2. ☐ Does not require an escort to and from the vehicle but **cannot** be dropped off at home unless there is a visual contract between a home representative and the transportation staff.
3. ☐ Needs to be escorted to and from the vehicle by the home representative.

Transportation Standards

- If numbers two and three above are checked and no one is home when the vehicle arrives. The vehicle will continue on its usual route and bring the individual back to the day service site or an authorized location. The home representative is the responsible to transport the individual back home on this day.
- Day service participants are responsible for being ready to board the vehicle when it arrives at their home in the morning. The waiting period for picking up and individual is three (3) minutes. If there is no response from within the home during that time, the vehicle shall continue its route and will not return that day. It is then the responsibility of the home representative to transport the individual to the program site.
- If there are repeated problems with pick up or drop-off of the individual, transportation may be suspended until a corrective plan of action is implemented.
- Transportation is provided on a curb to curb basis. Transportation staff are not responsible for escorting individuals to and from the home. The day service and/or transportation provider's responsibility for the individual coaxes when they step off the vehicle.

I have read, understand and agree to follow the transportation standards.

_____ _____

Signature of Individual or guardian where applicable Date

_____ _____

Signature of home representative (if different than above) Date

Annual Review: A new form must be completed a minimum of every five years. In interim, this form needs to be reviewed by the IDT annually. If there are no changes, complete the information below. If there are changes a new form must be completed and signed.

Review Date	Signature of IDT Representative
1.	
2.	
3.	
4.	
5.	

Form #7

State of New Jersey
Department of Human services
Division of Developmental Disabilities

EMERGENCY CONSENT FORM
ADULT DAY SERVICES

In my capacity as the legally appointed guardian of _____,
(Print Name)

I hereby consent to any and all medical or surgical treatment, including hospital admission, examinations and diagnostic procedures, anesthetics, transfusions and operations, which, in the event of an emergency is deemed necessary by competent medical clinicians to save the life or preserve the health of the above named individual. I also approve the release from the case records of any medical history or other medical data, which would be necessary for the physician and/or hospital to administer the treatment.

It is understood that general consent is only applicable specifically and exclusively to emergency situations. In each and every other instance of elective medical and/or surgical treatment recommended by medical professionals, an explicit, individual consent must be requested within a reasonable advance time period.

Emergency treatment should be followed by prompt notification of the guardian by the person(s) responsible for care of the individual.

_____ _____
Signature of Legal Guardian Date

_____
Print Name

The Arc Mercer, Inc., Sharing Release Form
(to be used with photos, video and audio, which may or may not contain PHI)

1. I hereby grant the Arc Mercer, Inc. (herein after "Arc Mercer"), and its respective licensees, successors and assigns, the perpetual right to use, copy, publish and distribute any interview(s), photographs and/or videos (and any included PHI), as well as my name, for health information or promotional purposes (or any other purposes the Arc Mercer deems appropriate) in any print, electronic, digital or other medium, including social media. The Arc Mercer may disclose my interview, photograph and/or video (and any included PHI) to third parties who are assisting with preparing such content for publication.
2. I agree that the Arc Mercer has the right to edit, modify and alter interviews, photographs and/or videos or other such content in any manner as it deems appropriate. I agree that no materials need to be submitted to me for approval and that the Arc Mercer shall be without liability to me or others for the authorized use(s) of the aforesaid content and/or name. I understand that the Arc Mercer shall not be obligated to make any use of the rights set forth herein and that I will not receive any payment in connection with this Authorization and expressly waive any rights to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse informational and/or educational settings promoting Arc Mercer, Inc. within an unrestricted geographic area.
3. **If I am recipient of healthcare related services from the Arc Mercer,** I authorize Arc Mercer to disclose my name and any protected health information ("PHI") that is contained in any interview, photography or video covered by this Authorization and Release.
4. I understand that any PHI used or disclosed pursuant to this authorization may be subject to redisclosure by the Arc Mercer and may no longer be protected by federal law. If I am an Arc Mercer patient, the Arc will not condition treatment on whether I sign the Authorization and Release.
   (IF YOU ARE **NOT** A RECIPIENT OF HEALTHCARE SERVICES FROM THE ARC MERCER, PARAGRAPHS 3 AND 4 ABOVE DO NOT APPLY TO YOU).

This Authorization may be revoked in writing at any time except to the extent action has taken in reliance upon it. Furthermore, I understand that this authorization will remain in effect for eighteen months, unless specifically revoked by me, in writing. I further understand that there is no geographic limitation on where these materials may be distributed.

This Authorization shall be binding upon my survivors, heirs, descendants, administrators, executors and all others who have or may have a legal claim or rights by virtue of my agreeing to this Release and License. I also agree that I am 18 years or older. By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for the purposes specified herein.

SIGNED: _____ DATED: _____, 201__

PRINT NAME: _____

Authorization Signed by an Adult Guardian on Behalf of their Charge
I hereby confirm that I am the legal guardian for the person who name appears below and that I consent to all of the foregoing on their behalf:

SIGNED: _____ DATED: _____, 201__

PRINT NAME OF GUARDIAN: _____

PRINT NAME OF CHARGE: _____