

# Daniel's Place Guest Intake Packet:

Thank you for choosing Daniel's Place for your respite care needs. This packet helps us to provide safe, compassionate, & individualized care for your loved one.



Please complete all sections thoroughly. Incomplete or insufficient information may delay approval, and we will be unable to provide respite stays for your loved one until all required details are submitted. If any section is missing or unclear, the form will be returned with the areas needing attention clearly highlighted. This process helps us ensure the safety of your loved one and allows our staff to provide the highest quality care possible.

## Guest Information:

Full Legal Name: \_\_\_\_\_ Preferred Name/Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Guardian/Caregiver Information:

Name(s): \_\_\_\_\_

Legal Guardian (if different): \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

Email Address (For billing and updates): \_\_\_\_\_

Employer(s) (if needed in emergency): \_\_\_\_\_ Employer Phone: \_\_\_\_\_

## Permission for Activities:

- | Yes                      | No                       | Activity:   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Swimming (required 1-to-1 supervision for all swimming) |
| <input type="checkbox"/> | <input type="checkbox"/> | Park or Playground                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Car Rides   |
| <input type="checkbox"/> | <input type="checkbox"/> | Shopping  |
| <input type="checkbox"/> | <input type="checkbox"/> | Community Integration Activities                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Walks (w/wagon, stroller, or wheelchair, if needed)     |
| <input type="checkbox"/> | <input type="checkbox"/> | Restaurant (i.e. Mc Donald's, Dairy Queen, etc.)        |
| <input type="checkbox"/> | <input type="checkbox"/> | Church or Concert                                       |

I, \_\_\_\_\_, give Daniel's Place Staff permission to allow  
(Parent, caregiver, guardian)  
\_\_\_\_\_ to participate in the activities marked "yes".  
(Guest's Name)

Signature: \_\_\_\_\_  
(Parent, caregiver, guardian)

Date: \_\_\_\_\_

**Diagnosis:**



**Description of condition:**

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	Yes	No	Partial	If yes or partial please explain:
Physically Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Visually Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Verbally Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Emotionally Challenged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Behaviorally Challenged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Intellectually Challenged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

**Level of understanding:**

- Total       Moderate       Limited       Unknown

**List any adaptive equipment:**

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Typical emotional state: \_\_\_\_\_

Flight Risk?  Yes  No      Elopement Risk?  Yes  No

If yes to either, what does the intervention plan look like? \_\_\_\_\_

**Medical Information:**



Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Specialists (if applicable): \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_ Reason: \_\_\_\_\_

**Allergies:** Please list & describe reactions:

Food: \_\_\_\_\_

Medication: \_\_\_\_\_

Environmental: \_\_\_\_\_

**Seizure History:** If yes, provide type/frequency/triggers-In addition, A Full Seizure Plan will need to be completed:

Yes  No  Remission

\_\_\_\_\_  
\_\_\_\_\_

**Seizure Protocol:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medication Information:** An additional Medication Administration Consent Form must be completed and signed for all medications

Medication:	Dose:	Time(s) Given:	Administration Type:	Purpose:

**Additional Medical Information:** *Please list and describe any other medical or safety risks that would be helpful for staff to know*



**Nutritional Intake:**

By Mouth

Eating  Liquids  Medication  All

**Eating:**

Independent

Some Assistance

Total Assistance

Finger Feed

*Explain:*

**Drinking:**

Independent

Some Assistance

Total Assistance

*Explain:*

Consistency of Beverage: \_\_\_\_\_

Chewing and swallowing difficulty? \_\_\_\_\_

*Explain:*

Feeding Tube

Eating  Liquids  Medication  All

*Type:* \_\_\_\_\_ *Feeding Rate:* \_\_\_\_\_

*Feeding Schedule:* \_\_\_\_\_

*Flush Protocol:* \_\_\_\_\_

*Other Information:*

Choking/aspiration risk?  Yes  No If yes, provide intervention methods: \_\_\_\_\_

Special Positioning?  Yes  No If yes, explain: \_\_\_\_\_

Dehydration Risk?  Yes  No If yes, provide intervention methods: \_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_



**Mobility:**

Independent       Walker       Wheelchair       Other \_\_\_\_\_

Requires Assistance    Explain: \_\_\_\_\_

Fall Risk?    Yes    No    If yes, provide intervention methods: \_\_\_\_\_

Independently       Single Person       Two Person       Hoyer Lift  
    Transfers                      Transfer                      Transfer

**Communication:**

Verbal                       Non-Verbal                       Other \_\_\_\_\_

Limited Speech               Communication Device

Sign Language

**Toileting:** *We check diapers every hour unless otherwise instructed*

Independent               Needs Reminders               Potty Training

Requires Assistance     Complete Incontinence     Pull-ups/Briefs

Menstrual Periods?    Yes    No    If yes, provide any special instructions: \_\_\_\_\_

Can use standard toilet fixtures?    Yes    No    Comment: \_\_\_\_\_

Can clean themselves after toileting?    Yes    No    Comment: \_\_\_\_\_

How often do they have a BM? \_\_\_\_\_ Constipation Risk?    Yes    No

Constipation intervention plan: \_\_\_\_\_

**Activities:** Circle all that apply



Music      TV/Movies      Reading      Crafts      Cars/Trucks      Building Blocks

Card Games      Puzzles      Music      Coloring/Drawing      Singing      Dancing      Being Read to

Video Games      Balls      Dolls      Walks      Toys with lights/sounds      Other \_\_\_\_\_

**Favorite TV Shows/Movies:** \_\_\_\_\_

**Favorite Toys/Games:** \_\_\_\_\_

**Favorite Activities:** \_\_\_\_\_

**Favorite Music:** \_\_\_\_\_

**Enjoys interacting with others?**  Yes  No  Sometimes \_\_\_\_\_

**Enjoys socializing with others?**  Yes  No  Sometimes \_\_\_\_\_

**Naps?**  Yes  No  Sometimes Usual time(s): \_\_\_\_\_ Length of nap: \_\_\_\_\_ Location: \_\_\_\_\_

**Are there any skills or other items we can work on with your loved one during their stay?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Describe any behavioral problems:**



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**Methods that work best for controlling unwanted behavior?**

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**Rewards for good behavior?**

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**Situations that might cause distress or be a trigger**

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**What is the most important thing we should know about your loved one?**

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**What are your biggest concerns about leaving your loved one in our care?**

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I certify that all information provided regarding my loved one is accurate, current, and complete to the best of my knowledge. I understand that Daniel's Place relies on this information to provide safe, appropriate, and effective care. I acknowledge that failure to provide accurate, complete, and up-to-date information may impact the ability of Daniel's Place to safely care for my loved one and may result in denial or discontinuation of services. I agree to promptly notify Daniel's Place of any changes in my loved one's medical condition, behaviors, medications, or care needs. I understand that this information will be used in accordance with applicable privacy laws and organizational policies.

Signature: \_\_\_\_\_  
(Parent, caregiver, guardian)

Date: \_\_\_\_\_

Guardian Initials: \_\_\_\_\_

Revised Date(s): \_\_\_\_\_