



GARDENHOUSE
MORRO BAY

LIFE FOR MATURE ADULTS

INCLUDING THOSE WITH ALZHEIMER'S AND OTHER DEMENTIAS

480 Main St., Morro Bay, CA 93442

805-772-7181 fax 772-7762

www.gardenhousemorrobay.org

Mature Adult Day Assistance, Inc. Tax ID#077-0476402

LIC # 405800862

INQUIRY FORM

Your Name: _____ Date: _____ Permanent Respite

Address: _____

E-Mail: _____ Phone: _____

Inquiry made for: Mom Dad Aunt Uncle Grandmother Grandfather Friend Other

Prospective Resident Name: _____ Age: _____ Date of Birth: _____

Address: _____

Current living situation: Assisted Living Community SNF Alone Family
 Hired Caregiver Other: _____

Timeframe for moving: _____

Needs & Services Assessment:

Yes	No	Sometimes		Yes	No	Sometimes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires personal care
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bathing assistance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walker/Rollator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing Assistance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication assistance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confused/forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Assistance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wandering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sun downing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of UTI

Comments, Medical Condition(s), Diagnosis(es), Health History: _____

Falls: yes no If yes, explain: _____

Recent Hospital Visit: yes no If yes, explain: _____

Current Physician: _____ Phone: _____ Fax: _____

How did you hear of us? _____

Are you working with a placement agency? yes no If yes, Agency Name: _____

