3953 Pender Drive, Suite 100
Fairfax, VA 22030
Voice (703) 204-4664
Fax (703) 204-0509
www.insightmcc.org

IMCC Admission Process

1. Complete and submit the application form along with the application fee.
2. Consult with the Program Director to determine availability for your preferred days of attendance.
3. Once the Program Director confirms a spot is available, complete the physical and TB screening with your physician. **The physical and TB screening must be signed by a physician and completed no more than 30 days prior to admission (the first official date of attendance)**.
4. Once the physical is scheduled, call to arrange an intake assessment and admission paperwork/contract signing. Please bring: the completed medical paperwork, the lifestyle biography, copies of the participant's insurance cards, power(s) of attorney, and any advanced medical directives, the names/addresses/phone numbers of two additional local emergency contacts, and a check for the first full month's payment.
5. Schedule and arrange for transportation.
6. Determine start date and sign contract.
7. Discuss any dispensing of medication and dietary issues with our nurse.
8. Bring in a photo for our family wall! Any standard sized photo (4" x 6" or larger) is preferred.
9. Responsible Party (and other family or caregivers) attend New Family Orientation session within 60 days of admission.

First day of Attendance

1. Plan on the new participant attending for a shorter day, about 4.5 hours.
2. Bring a change of clothing (and Depends, if used) labeled with participant's name.
3. Medications administered at Insight are to be brought in by the responsible party in the original container with a matching doctor's order.
4. Make plans for yourself to enjoy the day.

*Don't forget to pick up your copy of the family handbook!

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INSIGHT MEMORY CARE CENTER

APPLICATION FORM

NAME: _____ Date of Admission: _____

Address: _____ Telephone: (_____)_____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Marital Status: _____

Medicare Number: _____ Effective Date: _____

Medicaid Number: _____ Effective Date: _____

Other Insurance: _____ Place of Birth: _____

Birth Date: _____ Age: _____ ____ Hospital Preference: _____

Referred By: _____ Hospital Address: _____

NAME OF RESPONSIBLE PARTY/GUARDIAN

_____

Address_____

_____

Telephone (w) (_____) _____

(h) (_____) _____

NAME OF NEAREST RELATIVE

_____

Address_____

_____

Telephone (w) (_____) _____

(h) (_____) _____

NAME OF NON-FAMILY EMERGENCY CONTACT

_____

Address_____

_____

PERSONAL PHYSICIAN

_____

Address_____

_____

Telephone (w) (_____) _____ Telephone (w) (_____) _____

(h) (_____) _____

PRIMARY CARE PROVIDER AGENCY/SOCIAL/CASE WORKER

_____ _____

Address_____ Address_____

_____ _____

Telephone (w) (_____) _____ Telephone (w) (_____) _____

Please rate the following on a scale of 1 to 5, with 1 = very poor and 5 = very good

Sight	_____	Alertness	_____
Use of hands	_____	Orientation	_____
Hearing	_____	Ability to feed self	_____
Speech	_____	Ability to walk	_____

Other disabilities:

_____

_____

FOR OFFICE USE ONLY:

Level of Care: _____ How many days per week: _____

Transportation: _____

Medicaid/Scholarship: _____

Date of admission: _____

Application has been closed: Yes ☐ No ☐ Date closed: _____

Reason:

Date and reason for leaving IMCC:

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FEE AND PAYMENT POLICIES

Effective May 1, 2018

Insight Memory Care Center (IMCC) operates on a fee-for-service basis with a goal of providing the highest quality dementia-specific care at an affordable rate. Fees are reviewed each year and adjusted if needed.

We tie the cost of care to the level of service provided. All potential participants are assessed and assigned to Level II or III. Monthly fees are figured according to levels of care. Each participant is reassessed quarterly and families are notified in advance if there is a change in the level of care needed.

The Program Director will help you select a schedule of attendance at the Center for your family member (see attached schedule and rate sheet) and you will pay for that schedule in advance on a monthly basis. We strongly encourage you to carefully select a schedule that is viable for your family, as we cannot always accommodate last-minute schedule changes.

Services are accounted for on a prospective monthly basis and a statement of services, charges and payments will be sent to the responsible party on a monthly basis. Payment must be received by the 5th of the month for which services are received (for example, payment for June services are expected by June 5th).

For those who have difficulty meeting the cost of care, the Board has established the *Financial Assistance Fund* with the goal that no one is turned away for lack of funds to pay for services. Feel free to contact us for an application for financial assistance.

Insight Memory Care Center Fees

Effective 5/1/18

Days per Week	**Blue** ***(Per Month)***	**Orange** ***(Per Month)***	**Coral** ***(Per Month)***
5 days per week	$2,700	$2,900	$3,100
4 days per week	$2,315	$2,485	$2,660
3 days per week	$1,800	$1,940	$2,070
2 days per week	$1,285	$1,385	$1,475

Bathing Fee

Our facility is equipped with a shower room where bathing services can be provided to the participants. The fee for each bathing occurrence is $40. This includes a full shower, oral care, shaving (men) and a manicure.

Out of County Meals Fee

Our meals (breakfast, lunch, and two snacks) are provided by Fairfax County. These meals are paid for by the taxpayers of Fairfax County; IMCC does not pay for the meals.

Thus, if your loved one lives outside of Fairfax County you will be billed for meals for the days your family member is scheduled to attend unless you cancel by 8:30 am. The current rate for meals is $9.30 per day. We will ask that checks for this service be made payable to Fairfax County.

Missed Days

If your loved one misses a scheduled day for any reason beyond our control (including inclement weather, illness, or a situation that requires us to close for a full day), we will be glad to try to accommodate a make-up day within the month of the missed day, if possible. Please note that this is dependent on a number of factors, including available capacity.

Unfortunately, we cannot reschedule days missed due to the Center being closed for a scheduled holiday. You will receive a calendar of scheduled holidays by the beginning of each year.

Additional Days

If you need to occasionally add a day to your schedule, we will try to accommodate your request.
Please call the at least 24 hours in advance. The fee for an additional day is $140.

Withdrawal

We request that any participant looking to withdraw from the program submits written notification to IMCC of at least 14 days. In the case of discharge due to medical reasons or death, this 14 day notice is waived. A refund may be provided for any remaining unused days after the agreed date of termination that month. This refund will be provided within 60 days.

In the event the participant leaves IMCC but wants to hold their space, IMCC will hold the slot for as long as instructed in writing. Regular payment is required during this time. In the event payment is not received for position hold, a discharge letter will be issued for non-payment.

Questions about any financial matters should be asked of the Director of Finance and Personnel.

Registration Fee

There is an application/assessment fee of $75.00 due at the time of enrollment.

Late Pick-up Fees

The Center is opened from 7:30 a.m. - 5:30 p.m. We appreciate everyone's cooperation in helping our staff to get off work on time in the evening. Our late pick-up fees are as follows:

$15.00 for pickup up to 5 minutes late;
$30.00 for pickup between 5 to 15 minutes late;
$55.00 for pickup between 15 minutes and a half hour late;
$80.00 for pickup between a half hour and an hour late;
$105.00 for pickup after an hour late and every hour thereafter.

Since the Center can not leave a participant alone, our employees must be paid for the time they are here after their scheduled hours. Licensing requires at least two staff members to be present even when only one participant is awaiting pickup.

Late Payment and Non-payment

Payments are due on the 5th of each month.

If a bill is not paid in full by the 15th, the Director of Finance and Personnel will call and remind the responsible party to pay the bill. IMCC has the right to assess a late fee on any bills not paid in full by the 15th.

If outstanding payment is not received by the end of the month (last business day), a certified letter will be sent stating the responsible party has 14 days to submit the outstanding balance, or the responsible party will be issued a 30 day discharge letter.

If unusual circumstances arise which affect the responsible party's ability to pay please contact the Director of Finance and Personnel.

Returned Checks

There is a $30.00 charge for returned checks.

Financial Assistance Fund (FAF)

It is the Center's goal not to turn anyone away for lack of ability to pay. Therefore the Board actively fundraises for the FAF so that it can consider requests for reductions in charges when there is financial hardship. The Board of Directors has an administrative committee to review FAF applications from families in need of assistance and recommend fee reduction amounts. The Board ultimately approves the level of assistance. It is important to give accurate and complete information since the committee decision is based on what is read.

All information is kept confidential. The requests for FAF renewals are reviewed in the spring for the upcoming fiscal year. New requests are considered as they are received. Information and questions go to the Executive Director who will relay them to the Board.

PARTICIPANT LIFESTYLE BIOGRAPHY

Participant Name: _____ Nickname _____

Name and relationship of person completing form: _____

Date of Birth: _____ Birth Place: _____

BACKGROUND AND SOCIAL ASSESSMENT

Reading, Writing, and Arithmetic

Schools attended: _____

College Degree: _____ Advanced Degree: _____

Military Service

Did you serve in the Military: ☐ Y ☐ N Branch: _____

Did you serve during any Wars ☐ Y ☐ N Which One(s): _____

Did you receive any Metals or Commendations ☐ Y ☐ N Which One(s): _____

Did your Spouse serve in the Military: ☐ Y ☐ N Branch: _____

Did they serve during any Wars ☐ Y ☐ N Which One(s): _____

Did your spouse receive any Metals or Commendations: ☐ Y ☐ N

While in the Military, where were you stationed?

_____

_____

It's a Family Affair			
Name of Spouse(s):			
Marital Status:	M ☐ S ☐ W ☐ D ☐	If deceased, year of death:	
Mother's Name:		Occupation:	
Father's Name:		Occupation:	

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PARTICIPANT LIFESTYLE BIOGRAPHY

Sibling's Names (and age)

Children's Names (and age)

Grandchildren's Names (and age)

Great Grandchildren's Names (and age)

Shuffle Board on the Lido Deck!

When interacting with other people, are you: ☐ Social Butterfly ☐ Wallflower

Would you consider yourself a: ☐ Hugger ☐ Hand-shaker ☐ Waver

Can you: ☐ Whistle ☐ Snap Your Fingers ☐ Carry a Tune ☐ Play an Instrument (which one: _____)

Can you: ☐ Read ☐ Write ☐ or both?

Do you enjoy being around other people? _____

Is the individual aware of his/her diagnosis?_____

What life stories are important to him/her?

_____

_____

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PARTICIPANT LIFESTYLE BIOGRAPHY

RECREATION THERAPY LEISURE ASSESSMENT

Favorite season: _____

Favorite thing in nature:_____

Favorite sport/physical activity:_____

Favorite hobby/pastime:_____

Favorite place to visit: _____

Favorite holiday: _____

Favorite pet/animals: _____

Favorite snack: _____

Favorite reading material: _____

Favorite restaurant: _____

Favorite food to eat: _____

Favorite day of the week: _____

Favorite subject in school: _____

Favorite thing to wear: _____

Favorite thing I own: _____

Favorite room in my house: _____

I always dreamed I could be: _____

What I did for a living: _____

Favorite job:_____

My biggest accomplishment in life:_____

My favorite memory is:_____

Righty or a Lefty:_____

Do you speak any Foreign Languages? _____

Something I'd like to learn is:_____

When these things occur, it tends to make me frustrated or anxious:_____

_____

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insight MEMORY CARE CENTER

PARTICIPANT LIFESTYLE BIOGRAPHY

RECREATIONAL THERAPY ACTIVITIES ASSESSMENT

Listed below are many of the activities we offer in the day center. Please check the activities of interest:

Social Activities	✓
Current Events	☐
Pictionary	☐
Music Based Topics	☐
Name That Tune	☐
Group Discussions	☐
Board Games	☐
Scenario Based Discussions	☐
Other:	☐

Physical Activities	✓
Yoga/Tai Chi	☐
Bowling	☐
Fitness/ Exercise Program	☐
Dancing	☐
Walking Club	☐
Balloon Volleyball	☐
Badminton/Tennis	☐
Frisbee Toss	☐
Basketball	☐
Baseball/Softball	☐
Mini Golf	☐
Other:	☐

Spiritual Activities	✓
Gardening	☐
Spa Time	☐
Church-related topic discussion	☐
Meditation	☐
Other:	☐

Cognitive Activities	✓
Trivia	☐
Spelling Bee	☐
Jeopardy	☐
Word Games	☐
Puzzles	☐
Bingo	☐
Board Games	☐
Cards	☐
Other:	☐

Expressive Activities	✓
Painting	☐
Drawing	☐
Arts & Craft	☐
Poetry	☐
Sewing	☐
Wood Working	☐
Drama Activities	☐
Photo Shoots	☐
Photography	☐
Singing	☐
Other:	☐

Sensory Activities	✓
Pet Therapy	☐
Massage Therapy	☐
Cooking Group	☐
Other:	☐

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PARTICIPANT LIFESTYLE BIOGRAPHY

SPIRITUALITY ASSESSMENT

Religious Affiliation: _____ Church Attended (if any): _____

Regular Attendance: _____

What helps you get through (what do you do to cope with) the hard times in life?

_____

_____

What gives you joy or hope?

_____

_____

What makes you feel really alive?

_____

_____

When do you feel closest to God or Higher Power?

_____

_____

How would you describe your relationship with God?

_____

_____

What has been your biggest contribution to the world?

_____

_____

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PARTICIPANT LIFESTYLE BIOGRAPHY

MUSIC ASSESSMENT

Where did you grow up?_____ Native Language: _____

Do you have a favorite type of music? _____

What music did you listen to when you were young? _____

Who was your favorite performer, group, band, orchestra?_____

Did you sing at religious services?_____

Favorite hymns or other religious music?_____

Did you enjoy going to Broadway shows or musicals?_____

Did you have favorite TV shows or movies? _____
(theme songs from shows or movie soundtracks can elicit responses)

_____

Do you remember going to see live music (rock, symphony, ballet, jazz, polka, clubs?)

_____

Do you like to dance?_____ What type of dance?_____
(i.e., salsa, ballroom, swing, disco, square dance, polka, line)

Do you have a favorite classical music composer?_____

What songs did you dance to at your wedding? High school prom? _____

_____

Do you still have any records, tapes, CDs that were favorites? _____

Where can I find them? _____

Can you hum any favorite songs?_____
(can use Shazam to identify the song if you don't know it)

Other Notes: _____

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Instructions for IMCC Physical & TB Paperwork

In order to facilitate a smooth transition to Insight Memory Care Center, we ask that you please work with your physician to ensure all areas of the physical and TB form are filled out accurately and completely. The following instructions note common errors found on the physical and TB forms for admission to IMCC. *Unfortunately, missing or incorrect information on the physical will cause a delay in admission to the center.*

We thank you for your assistance in this matter!
IMCC Staff

Instructions: Each numbered instruction corresponds to an area noted on the physical or TB form. Please refer to the physical and TB forms.

1. MUST include: a DIAGNOSIS OF DEMENTIA, Alzheimer's, mild cognitive impairment, or other memory loss/cognitive decline.

2. Any allergies listed MUST be accompanied by the associated reaction.

3. Code status MUST be checked either "Full Code" or "DNR," which stands for Do Not Resuscitate. IF your loved one wishes to have a DNR code status, there is a State of Virginia one-page form that must be filled out and signed by the POA and the physician. This is separate from any prior advanced medical directives or living will your loved one may have. There is no fee for a DNR form.

4. Physician's signature MUST be present.

5. Date MUST be within 30 days of your loved one's first day at the center, according to state adult day health center regulations.

6. Medications MUST all be listed **on IMCC's form**, with **all information in each column complete**. Insight **CANNOT accept "see attached" medication lists.**

7. MUST be checked "NO" due to dementia, according to state adult day health center regulations.

8. MUST be checked "NO" due to dementia, according to state adult day health center regulations.

9. If "YES" is checked for restrictions/limitations on physical activity, the doctor MUST indicate what those restrictions are.

10. Physician's signature and the date MUST be present.

11. All prescription medications, over the counter medications, and nutritional or other supplements MUST all be listed **on IMCC's form**, with **all information in each column complete**. Insight **CANNOT accept "see attached" medication lists.**

12. Physician's signature and the date MUST be present.

13. Date MUST be within 30 days of your loved one's first day at the center, according to state adult day health center regulations.

14. Physician's signature and date MUST be present.

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INSIGHT MEMORY CARE CENTER

REPORT OF PARTICIPANT PHYSICAL EXAMINATION--ADULT CARE PROGRAM

Examination is to be completed by or under the direction of a licensed physician either within 30 days prior to acceptance for admission or within 30 days prior to admission.

Name of Applicant: _____

Applicant Address: _____

_____

Applicant Phone Number: _____

Applicant Date of Birth: _____

Print Physician's Name: _____

Physician's Address: _____

_____

Physician's Phone Number: _____

Physician's Fax Number: _____

Medical History and Current Status

Present Diagnoses and/or significant medical problems:

_____

Other Disabilities: (Please Specify)

_____

Allergies & Sensitivities: (inc. medications, food, animal):					
Reactions:					

Code Status (please check one):

☐ Full Code

☐ DNR ***(If DNR, please provide signed DNR form.)***

Relevant History

Physical History: _____

Mental History: _____

Fracture History: _____

Fall History: _____

Recent Surgery: _____

Recent Hospitalization: _____

Immunization History: _____

History of Drug Addiction or Excess Alcohol Intake:_____

Physical Examination: Blood Pressure: _____Pulse: _____ Weight: _____Height: _____Temp: _____

I[illegible]e attached tuberculosis screening evaluation **(must be dated within 30 days prior to acceptance or admission).**

Signature of Physician:_____ **Date of Physical**:_____

Participant Name: _____ DOB: _____

Recommendations for Care:

MEDICATIONS:

6.

Please use IMCC's Medication List (enclosed on page 3) for all prescribed and over the counter medications, vitamins, and supplements. ****Insight CANNOT accept printed out medication lists as attachments. All medications must be documented on pg. 3****

LIMITATIONS:

1. Is this person capable of administering his/her own medications without assistance?

7.

☐ No, due to dementia
☐ Yes

2. Is this person physically and mentally capable of self-preservation by being able to respond in an emergency to make an exit from the building or to a safe refuge in an emergency without assistance of another person, even if he/she may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command?

8.

☐ No, due to dementia
☐ Yes

3. Does this person have any restrictions/limitations on physical activities or program participation?

☐ No

9.

☐ Yes (**indicate type** of restrictions/limitations):
_____

DIET:

☐ Regular ☐ Controlled Carbohydrates ☐ Mechanical Soft ☐ Pureed

☐ Other: _____

Special diet or any food intolerances: _____

Please list any nutritional supplements (Ensure, Glucerna, etc.) on attached Medication List.

THERAPY :

List therapy (-ies), treatments or procedures the patient is undergoing or should receive and by whom:

_____

Other: _____

10.

Signature of Physician:_____ **Date**:_____

Participant Name: _____ DOB: _____

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11.

Medication List

All prescription medication, nutritional or other supplements, OTC medications, and vitamins MUST be completed ON THIS FORM (in the chart below). **Insight CANNOT accept "see attached" lists.**

Name of Medication	Dosage	Route	Frequency of Administration	Meds Given at Home or Center (Circle)	Diagnosis
Example: Tylenol	*325mg*	*PO*	*2 Tabs Q6H PRN*	*Home Center*	*Headache*
Example: Ibuprofen	*200mg*	*PO*	*2 Tabs BID – 1pm Dose Given at Center*	*Home Center*	*Shoulder Pain*
				Home Center	
				Home Center	
				Home Center	
				Home Center	
				Home Center	
				Home Center	
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				Home Center	
Discontinue ALL PRIOR ORDERS as this is a current and updated set of orders effective the date indicated below.					

Signature of Physician:______________________________ **Date**:________________

__****Since a Physician's Order is required for medication or treatment at the Center, please sign the above.*******__***

12.

Participant Name: ______________________________ DOB: ______________

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Report of Tuberculosis Screening

Date _____

Name _____ **Date of Birth** _____

13.

To Whom It May Concern:

The above named individual has been evaluated by _____.

(Name of health dept/facility)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form*.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form*.

_____ A tuberculin skin test (PPD) was administered on _____ and results, read on _____, were as follows: _____ mm _____ Negative _____ Positive.
Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

_____ The individual either is currently receiving or has completed adequate modification for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form*.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual had an *abnormal* chest x-ray on _____. **Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.**

Signature _____ **Date** _____
(MD or Health Department Official)

Address: _____ Phone _____
_____
_____

14.

Participant Name: _____ DOB: _____

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Examination is to be completed by or under the direction of a licensed physician either within 30 days prior to acceptance for admission or within 30 days prior to admission.

Name of Applicant:_____

Applicant Address:_____

_____

Applicant Phone Number: _____

Applicant Date of Birth:_____

Print Physician's Name:_____

Physician's Address: _____

_____

Physician's Phone Number:_____

Physician's Fax Number:_____

Medical History and Current Status

Present Diagnoses and/or significant medical problems:

_____

Other Disabilities: (Please Specify)

_____

Allergies & Sensitivities: (inc. medications, food, animal):					
Reactions:					

Code Status (please check one):

☐ Full Code

☐ DNR ***(If DNR, please provide signed DNR form.)***

Relevant History

Physical History:_____

Mental History: _____

Fracture History:_____

Fall History:_____

Recent Surgery:_____

Recent Hospitalization:_____

Immunization History: _____

History of Drug Addiction or Excess Alcohol Intake:_____

Physical Examination: Blood Pressure: _____ Pulse:_____ Weight:_____ Height:_____ Temp: _____

Please see attached tuberculosis screening evaluation **(must be dated within 30 days prior to acceptance or admission).**

Signature of Physician:_____ **Date of Physical**:_____

Recommendations for Care:

MEDICATIONS:

Please complete IMCC's Medication List (enclosed on page 3) for all prescribed and over the counter medications, vitamins, and supplements. ****Insight CANNOT accept printed out medication lists as attachments. All medications must be documented on pg. 3.****

LIMITATIONS:

1. Is this person capable of administering his/her own medications without assistance?

   ☑ No, due to dementia

   ☐ Yes

2. Is this person physically and mentally capable of self-preservation by being able to respond in an emergency to make an exit from the building or to a safe refuge in an emergency without assistance of another person, even if he/she may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command?

   ☑ No, due to dementia

   ☐ Yes

3. Does this person have any restrictions/limitations on physical activities or program participation?

   ☐ No

   ☐ Yes (**indicate type** of restrictions/limitations): _____

DIET:

☐ Regular ☐ Controlled Carbohydrates ☐ Mechanical Soft ☐ Pureed

☐ Other: _____

Special diet or any food intolerances: _____

Please list any nutritional supplements (**Ensure, Glucerna, etc**.) on attached Medication List.

THERAPY :

List therapy (-ies), treatments or procedures the patient is undergoing or should receive and by whom:

_____

Other: _____

Signature of Physician:_____ **Date of Physical**:_____

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Medication List

All prescription medication, nutritional or other supplements, OTC medications, and vitamins MUST be completed ON THIS FORM (in the chart below). **Insight CANNOT accept "see attached" lists.**

Name of Medication	Dosage	Route	Frequency of Administration	Meds Given at Home or Center (Circle)	Diagnosis
Example: Tylenol	*325mg*	*PO*	*2 Tabs Q6H PRN*	*Home* [✓ *Center*]	*Headache*
Example: Ibuprofen	*200mg*	*PO*	*2 Tabs BID – 1pm Dose Given at Center*	*Home* [✓ *Center*]	*Shoulder Pain*
				☐ Home ☐ Center	
				☐ Home ☐ Center	
				☐ Home ☐ Center	
				☐ Home ☐ Center	
				☐ Home ☐ Center	
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Discontinue ALL PRIOR ORDERS as this is a current and updated set of orders effective the date indicated below.

Signature of Physician:______________________________ **Date of Physical**:______________________

**********Since a Physician's Order is required for medication or treatment at the Center, please sign the above.**********

Participant Name: ____________________________ DOB: __________________

3953 Pender Drive, Suite 100
Fairfax, VA 22030
Voice (703) 204-4664
Fax (703) 204-0509
www.InsightMCC.org

Report of Tuberculosis Screening

Name _____ **Date of Birth _____**

To Whom It May Concern:

The above named individual has been evaluated by _____

(Name of health dept/facility)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis risk factors for developing active TB or known recent contact exposure. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ A tuberculin skin test (PPD) was administered on _____ and results, read on _____, were as follows: _____ mm _____ Negative _____ Positive.
Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

_____ The individual either is currently receiving or has completed adequate modification for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time. *Based on the available information, the individual can be considered free of tuberculosis in a communicable form.*

_____ The individual had an *abnormal* chest x-ray on _____. **Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.**

Signature :_____ **Date** _____
(MD or Health Department Official)

Address: _____ Phone _____
_____
_____

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2020 CALENDAR

Insight Memory Care Center will be closed for the following holidays/ staff development days.

Wednesday, January 1, 2020	**New Year's Day**
Monday, January 20	**Martin Luther King Jr Day**
Monday, February 17	**President's Day**
Friday, April 3	**Staff Training Day/Center Closed**
Monday, May 25	**Memorial Day**
Friday, July 3	**Independence Holiday**
Monday, September 7	**Labor Day**
Monday, October 12	**Columbus Day**
Wednesday, November 11	**Veteran's Day/ Staff Development**
Thursday, November 26	**Thanksgiving Holiday**
Friday, November 27	**Thanksgiving Holiday**
Thursday, December 24	**Winter Holiday**
Friday, December 25	**Winter Holiday**
Thursday, December 31, 2020	**New Year's Holiday**
Friday, January 1, 2021	**New Year's Day**

Snow Policy: **Insight Memory Care Center will close when Fairfax County Schools are closed**. *If Fairfax County Schools open late Insight Memory Care Center will open on time*. **Please note:** If Fairfax County Schools open late/close early – ***FASTRAN DOES NOT RUN.*** Under extreme weather conditions we may contact you to pick up your loved one early. You may want to listen to WTOP 1500 am for up-to-date weather conditions, or sign up for the Fairfax County Public Schools Keep In Touch notifications for closure information by email.

Absence: If your loved one will not be attending the Center on the regularly scheduled day, call the Center. Remember, in case of illness, accident or doctor's appointment, **call IMCC**.

***Fastran will not run if Fairfax County Schools open late or are closed.**