APPLICATION FOR ADMISSION

Person filling out the application **Date _____**

Name of Resident:_____
Present Location & Address:_____
_____

Person Inquiring _____
Relationship:_____
Address:_____
Phone # :_____
E-mail Adress:_____

List any previous Nursing Home/Hospital Stays: _____
_____
Current Physician:_____ Physician After Admission: _____
Marital Status:_____ Date of Birth:_____ Sex:_____
Will Patient be eligible for Medicare Skilled?_____ Will Patient be eligible for Medicaid?_____
Medicare #:_____ Medicaid#:_____
Social Security # _____
Private Insurance Name:_____ #:_____
Primary_____

Secondary _____
Is Patient a Community Care member? ____ # _____
Mark appropriate spaces with Yes or No.

	Yes	No		Yes	No		Yes	No
Alert_____	☐	☐	Ambulatory_____	☐	☐	Continuous oxygen ____	☐	☐
Slightly Forgetful ___	☐	☐	Walks with Assistance__	☐	☐	Breathing Treatments___	☐	☐
Confused_____	☐	☐	Walker_____	☐	☐	Smokes_____	☐	☐
Withdrawn_____	☐	☐	Wheelchair/Geri Chair__	☐	☐	Still Drives_____	☐	☐
Comatose_____	☐	☐	Chair bed rest_____	☐	☐	Bed sores_____	☐	☐
Wanders_____	☐	☐	Total bed rest_____	☐	☐	Mental illness_____	☐	☐
Require Restraints___	☐	☐	Feeds self_____	☐	☐	Exhibits inappropriate		
Sociable_____	☐	☐	Eats with Assistance ___	☐	☐	Behavior_____	☐	☐
Incontinent_____	☐	☐	Swallowing Problems___	☐	☐	Noisy _____	☐	☐
Uses briefs_____	☐	☐	Tube feeding_____	☐	☐			
Catheter_____	☐	☐	Needs Therapy_____	☐	☐			
Colostomy_____	☐	☐	Uses Oxygen at times___	☐	☐			

Allergies:_____
Special Equipment:_____
Treatments:_____
Describe Appetite: _____
Food Dislikes:_____
Current weight:_____

Can the patient bear his/her own weight to stand?:_____
Date of last fall: _____ # of falls in last year:_____
Has the Patient ever been convicted of a sexual crime?_____

HISTORY OF CURRENT HOSPITALIZATION

History of Current Hospitalization or Current condition:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Check only those that apply:

Medical History			Surgical History	
☐ Afib	☐ Depression	☐ Malnutrion	☐ Amputation	☐ Mastectomy
☐ Arthritis	☐ Diabetes	☐ Mental Retardation	☐ Appendectomy	☐ Pacemaker
☐ Alzheimer's	☐ DJD	☐ Osteoporosis	☐ CABG	☐ Peg Placement/ Removal
☐ Blind	☐ DVT	☐ Parkinson	☐ Cataracts	☐ Spinal Surgery/ Fusion
☐ Brain Injury	☐ ESRD	☐ Pneumonia	☐ Central Line	☐ Tonsillectomy
☐ Cancer	☐ GERD	☐ Psych Disorder	☐ Cholecystectomy	☐ Trach
☐ CAD	☐ GI Tract Ulcers	☐ Renal Failure/ Insufficiency	☐ Craniotomy	
☐ Cataracts	☐ H/O Non-compliance	☐ Spinal Injury	☐ Colostomy	
☐ CHF	☐ HTN	☐ PVD	☐ Dialysis	
☐ COPD	☐ HOH	☐ TD	☐ Hysterectomy	
☐ Stroke	☐ Long Term Steroids	☐ VRE	☐ Joint Replacement	
☐ Dementia	☐ MRSA	☐ Other		
	☐ MI			
Other:				

List Diagnoses: _____
_____
_____

List any communicable diseases:_____
_____
_____

Does the Patient wear any of the following:

_____ Glasses

_____Dentures

_____ Hearing Aid

Please give a description of Patients current daily routine and the assistance needed:

_____
_____
_____
_____
_____
_____
_____

PLANNED PROCEDURES/TESTS	OTHER/ APPOINTMENTS

LIST THE MEDICATIONS KNOWN:

Medications	Dose	Route	Freq.	Start	Stop	Antibiotic use
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

How will Patient be transported? _____

Are all concerned family members in agreement with the Nursing Facility Placement? _____

Emergency Contact:_____ Phone Number: _____

_____

Address City State Zip Code

Power of Attorney:_____ Phone Number:_____

_____

Address City State Zip Code

Does Patient have a living will and/or a DNR (Do Not Resuscitate)? _____

PLEASE SIGN BELOW:

I hearby warrant and represent that the information provided is accurate and complete. I understand that the nursing facility will rely upon the accuracy and completeness of the above information in making a decision. Any false information presented could be grounds for discharge from this facility.

_____ _____

Resident's or Responsible Party's Signature Date

_____ _____

Financial Guarantor's Signature Date