Boardman Cottage - Application and Pre-Admission Form

I am applying for:

Boardman Cottage Adult Family Care Home

Adult Day Program

Island Neighbor Home Health Care

Respite Program

Rev. [05/01/2015]

Applicant's Name: _____/_ / _____

Date of Birth: _____Male/Female: _____ Marital Status_____

Address: _____

Religion: _____ Place of Birth: _____ _____

Height: _____ Weight: _____

Social Security Number: _____

Ambulatory: _____ (Yes/No) Lived Alone: _____ (Yes/No)

Highest Level of Education: _____ Occupation: _____

Admitted From: _____ _____Location: _____

If admitted from home, date of most recent hospitalization: _____ dd/mm/yyyy

Family / Responsible Person Contacts:

- Please indicate if the person listed as a contact has Power of Attorney or other special legal relationship to the patient. Please attach copy of Power of Attorney and Advance Directives.

Primary Contact:

Name: _____ Relationship: _____

Address: _____

Phone Number Home: _____Work: _____

Cellular: _____

Other Contact:

Name: _____ Relationship: _____

Address: _____ _____

Phone Number Home: _____ Work: _____

Cellular: _____

Other Contact:

Name: _____ Relationship: _____

Address: _____ _____

Phone Number Home: _____ Work: _____

Cellular: _____

Advance Directives: ____Living Will____POA_____Durable POA____Healthcare POA

Must attach copy of all checked off.

Financial arrangements: _____Yes_____No. If no, invoices will be sent directly to you. If yes, to whom would bill be directed? (Name, Address, Phone number)

Monthly Income of Applicant_____SocialSecurity_____Other_____

MaineCare Applied for on __/__/__ (or Estimated Date MaineCare applied for__/__/__)

Copies of all checking and savings account statements for past two months must be attached to this application .

Facility Use Only

Admission Date: _____

Coming by: _____ Room Assigned:

_____

Assessment(To be done by Facility or Primary Care Provider)

Applicant's Name: _____ Age: _____

Sex: _____

Date of Assessment_____

1. Present Mental Status:

Alert _____ Disoriented _____ Noisy _____ Depressed _____ Abusive _____

Oriented _____ Anxious _____ Quiet _____ Withdrawn _____ Noncompliant

Decisions Consistent & Reasonable _____ Lethargic _____ Suspicious _____ Unresponsive _____

Comments:

_____

_____

_____

_____

_____

_____

2. Activity / Mobility Transfers Locomotion:

Dependent for all position changes _____ Full Assist _____ Bedfast _____ Limited Assist _____

Wheelchair _____ OOB to chair _____ Supervision _____ Walker _____ Ambulatory _____ OOB ad lib _____ Cane

Other (describe) _____

3. Diet / Nutrition:

Type of Diet_____

Chewing or Swallowing Problems _____

NPO _____

Artificial Nutrition (PEG, TPN, PPN, etc.) or Hydration (IV) explain:

_____ _____

_____

_____

_____

_____

Height _____ Weight _____ Usual Weight Prior to Illness

4. List of All Allergies:

_____

_____

_____

5. Communication:

Language Spoken: English _____ other (specify) _____

Aphasia _____Speech Slurred or Garbled _____Non-communicative_____

6. Special Needs / Appliances / Equipment:

Oxygen (mode of delivery and l/min) _____ Incontinent of Urine _____

Tracheostomy (size & make) _____ Foley Catheter _____

Suction _____ Incontinent of Feces _____

Humidifier _____ Ostomy (specify) _____

Nebulizer _____

Wound Care: (explain in detail site, origin, procedure)

_____

_____

_____

_____

_____

Other Issues / Needs:

_____

_____

_____

_____

_____

7. Cooperative (describe and explain): _____

_____

_____

_____

8. Smoking: Currently Smokes _____ Packs per day _____ has Quit - When?_

Medical Summary(To be completed by Primary Care Provider)

Applicant's Name: _____ _____ Age: _____ Sex: _

Brief Medical Summary and Course of Treatment:

_____

_____

_____

_____

_____

TB Screen PPD (required):_____ Results Date:

Chest X-Ray (attach report):_____ Results Date:

Pneumococcal vaccine: _____ Results Date:

Influenza vaccine: _____ _____ Results Date:

Infectious Diseases over the past 90 Days:

_____

_____

_____

_____

_____

_____

List Current Medications and Dose: (Attach additional notes)

Allergies:

If there is a history of Mental Illness, please explain:

_____

_____

_____

_____

_____

Please stamp, type, or print the Name, Address, and Telephone Number of Physician:

Signature of Physician: _____ _____ Date: _____