IMPORTANT THINGS YOU SHOULD KNOW ABOUT ME…

My Name ________________________________ My Age _______ My Physician __________________
I like to be called_______________________________

MY HISTORY – GENERAL PAST

Education________________________Occupation______________________Year Retired__________

Spouse______________________ Date Married____________ Date Deceased_________________

Children (names/ages/residences)____

____

Admitted from ____
Previous Living Arrangements: Lived Alone Lived Alone with Assistance Lived with Family
Other _________________________ Reason for Admission __________________________________

MY DAILY ROUTINE / SLEEPING PREFERENCES

What time do you go to bed? ___________________ What time do you get up? __________________

Do you take naps regularly during the day? YES NO Do you go out one or more days a week? YES NO

Do you stay busy with hobbies, reading or fixed daily routine? YES NO

Please list____

Do you spend most of the time alone? YES NO Do you move independently indoors? YES NO

Do you use tobacco products? YES NO

MY SOCIAL / INVOLVEMENT PATTERN

Do you have daily contact with relatives or close friends? YES NO

Do you usually attend church? YES NO Do you find strength in faith? YES NO

Do you have a pet? YES____________ NO Are you involved in group activities? YES NO

What kind of activities?____

MY RELIGION PREFERENCE

Religion____

Church___________________________________ Pastor_________________________

Address__________________________________ Phone_________________________

MY EMOTIONAL AND MENTAL STATUS SUMMARY

Alert / oriented to person, place, time and situation

Short term memory loss, periods of confusion

Delusions present Hallucinations present Wanderer / elopement risk

Safety risk due to fall history Other____________________________

Happy / pleasant Sad / upset at times Flat affect Confused at times

Dx of Depression Conversational Other ____________________________________

MY MEDICAL STATUS REPORT

Diagnoses ____

Allergies ____

Dressing / TX to the skin *(Specify)* __________________ Oxygen- *if yes,* Intermittent OR Constant

Tracheotomy *(Specify)* ___________________________ Suction *Specify frequency*________________

Hearing aides _________________________________ Glasses _____________________________

MY NUTRITION PREFERENCES

Do you have a special diet? _____________________ Do you have distinct food preferences? YES NO

Please list your favorite foods____

Do you have specific food dislikes?____

Do you eat between meals? YES NO What do you eat as snacks?_______________________________

Do you use alcoholic beverages at least weekly? YES NO

ACTIVITIES OF DAILY LIVING & OTHER PREFERENCES

Do you stay in pajamas much of the day? YES NO

Do you wake up at night to go to the bathroom most nights? YES NO Number of times __________

Do you have irregular bowel movements? YES NO Continent?___________________________________

Incontinence Products__________________________________ Catheter use? YES NO

Do you prefer a shower or a bath? ________________ In the AM or PM? __________________

Do you need assistance transferring? __________ Walking?___________ Using the restroom?___________

Prior ADL function / assist needed ____

Dressing: Total assistance Partial assistance Supervision only Independent

Bathing: Total assistance Partial assistance Supervision only Independent

FUNCTIONAL INFORMATION (Things that will help me go about my day)

Transfers: Mechanical lift 2 person 1 person Supervision only Independent

Ambulation: Non-ambulatory 2 person 1 person Supervision only Independent

Weight bearing status____

Equipment utilized: Commode CPM Machine Walker Cane Wheelchair

Transfer board Special recliner / chair in room Other___________________________

PLACEMENT / DISCHARGE GOAL: Skilled care Long-term care Dementia Care Unit

Discharge Goal:____

This individual will be admitted to The Alverno on _________________, to Room___________.

JUST THE FACTS…

Office Use Only:
Computer #__________ Room #__________ Admit Date________________ Admit Time___________

Last Name____________________________ First Name___________________________ M.I.________

Medicare # ___________________________________ Effective Date______________________

Social Security # ____

Resident Current Address____

City/State/Zip ____ County___________________

Current Phone________________________ Transfer phone here? YES NO Skilled & wants phone at fee YES NO

DOB ______/_____/________ Place of Birth____________________________ Level of Care __________

Referred from ____ on ______/______/20_______

Dates of hospitalization _______________to________________ Primary Language_____________________________
(if applicable)

PHYSICIANS

Primary Physician (Admitting) ____

Address____ Phone__________________________________

Specialist (heart doctor, etc.) _________________________________ Psychiatrist_______________________

Podiatrist___________________________ Routine? YES NO If Problem? YES NO

Dentist_____________________________________ Ophthalmologist______________________________

Pharmacy Preference___________________________ Hospital Preference____________________________

Ambulance Preference Medic Other_____________________________________

DEMOGRAPHICS

Sex M F Race_________________ U.S. Citizen YES NO If NO ________________

Marital Status Married Single Widowed Divorced Separated

Veteran YES NO Spouse of Veteran YES NO Branch _____________________________

Dates of Service ____________________ SN#_______________ Discharge Status_____________________

Information provided by __________________________________ Date _____________________

NEXT OF KIN EMERGENCY CONTACTS

Emergency Contact Last Name________________________________ First_____________________________

Address ____

City/State/Zip _____________________________________ Email____________________________________

Relationship _______________________________ Legal Relationship _____________________________

Home Phone_____________________ Bus. Phone____________________ Cell Phone __________________

1st Contact Last Name_____________________________ First Name _________________________________

Address ____

City/State/Zip _____________________________________ Email ____________________________________

Relationship _______________________________ Legal Relationship _____________________________

Home Phone_____________________ Bus. Phone______________________ Cell Phone _________________

2nd Contact Last Name_____________________________ First Name ________________________________

Address ____

City/ State/ Zip __________________________________ Email______________________________________

Relationship _______________________________ Legal Relationship _____________________________

Home Phone_____________________ Bus. Phone______________________ Cell Phone _________________

FUNERAL HOME INFORMATION (Required information)

Funeral Home____ Phone________________________

Address____

RESPONSIBLE PARTY / BILLING PREFERENCES

After admission will resident receive personal mail? YES NO

If No, mail (including monthly bill) is sent to:

Name____ Phone _______________

Address/City/State/Zip____

After admission will resident receive business mail? YES NO Receive Bill? YES NO

If No, mail/bill is to be sent to the following Responsible Party:

Name____ Phone_______________________________________

Address/City/State/Zip____

Relationship____

FINANCIAL STATUS REPORT

My Name ____

SUPPLEMENTAL INSURANCE **(Please bring all cards; we need a copy)**

1st Supplemental Health Insurance____

Policy # _________________________________ Group # _________________________________

Address/City/State/Zip____

Long Term Health Care Insurance____

RESIDENT PAYMENT PLAN Private Pay Title XIX (Medicaid)

If Title XIX, Title XIX #___________________________ Effective Date ____________________

The following applies to LONG-TERM CARE residents only

Resident Name: ___________________________

Financial Asset & Income Checklist

Type of Asset	Y/N	Amount or Value	Owner(s) of Asset
Checking Account(s)			
Savings Account(s)			
CD's			
Savings Bonds			
Money Market Funds			
Stocks or Mutual Funds			
Trust or Annuity			
Pension, IRA, KEOGH, 401K, 403B			
Cash on Hand			
Home (specify in trust, estate or private owner)			
If Yes in regard to Home, Assessed Value:			
Real estate (not your home)			
Life Insurance (cash value or death benefit)			
Burial Trust/Funeral Contract(s)			
Prepaid Burial Plot			
Car, Truck, Boat, Snowmobile, etc.			
Other Assets			

Type of Income	Y/N	Amount	Specify Whose Income
Social Security			
Supplemental Security Income (SSI)			
Retirement Benefits			
Veterans Benefits			
Disability Benefits			
Rental Income			
Worker's Compensation			
Child Support			
Unemployment Compensation			
Military Allotments			

Financial Asset & Income Checklist - Continued

Type of Income - Continued	Y/N	Amount	Specify Whose Income
Gaming Distributions (casino profit sharing)			
Other Income			
IPERS or Civil Service			
Railroad Retirement			
Money from Interest			
Other Income			
Personal Property	**Y/N**	**Amount**	**Additional Comments**
If you own property - is there a mortgage against the property?			
Have you transferred, sold or given away any property (land, cash, car, home, etc.) In the last 5 years?		If Yes, please describe what and to whom and value.	
Other Comments:			

Signature

Date