

St. Francis Health Care Centre
401 N. Broadway Street
Green Springs, OH 44836

Admissions (419) 639-6224
Admissions Fax (419) 639-6222

Nursing Facility
PREADMISSION APPLICATION

Name: _____ Age: _____ Birth Date: _____ Application Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____ County: _____

Birthplace (City/State/County) _____ Sex: M F Social Security #: _____

Home Phone: _____ Civil Status: M S W Sep Race: _____ Education Level: _____

Name of Spouse: _____ Address/Phone: _____

Maiden Name: _____ Military Service: Y N Years: _____ Ethnic Group _____

Father's Name: _____ Maiden Name of Mother: _____ # of Children: _____

Occupation: _____ Place of Employment: _____

Retired: Y N Religion: _____ Church: _____

PERSON TO CONTACT ABOUT THIS APPLICATION (if other than applicant): _____

Phone: _____ Address: _____

PERSON FILLING OUT APPLICATION (if other than applicant): _____

Relationship to Applicant: _____

ROOM PREFERENCE: Private Semi Private Ward First Available

Nursing home placement is desired: As soon as possible (date: _____) Other (date: _____)

Has applicant or family member ever been a resident / patient of St. Francis Health Care Centre? Y N

If so, when? _____

Has applicant ever been a resident of another facility or nursing home? Y N

If so, give name of facility and dates? _____

EMERGENCY CONTACT:	POWER OF ATTORNEY:
Name:	Name:
Address:	Address:
City: ST: ZIP:	City: ST: ZIP:
Phone:	Phone:

LEGAL GUARDIAN, if any:

Name: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Phone (H): _____ Phone (W): _____

Applicant Name: _____

I. INSURANCE INFORMATION:

A. Medicare # _____ Medicaid # _____ County: _____

B. Other Insurances:

Name _____

Name _____

Address _____

Address _____

Policy # _____

Policy # _____

C. Person Responsible for account / send bill to:

Name _____

Address _____

Phone _____

II. FUNERAL ARRANGEMENTS:

In case funeral arrangements become necessary at some time, what is the name of the funeral home preferred: _____

Cemetery: _____ Doses applicant have a prepaid burial contract? Y N

Does applicant have life insurance to cover burial? Y N

Advance Directives: Living Will Durable Power of Attorney for Health Care. Last date document reviewed? _____

* Please attach copy of any Advanced Directives. Still current and accurate information? _____

Code Status: Resuscitate DNR Comfort Care Arrest DNR Comfort Care

III. MEDICAL HISTORY

A. Please list current diagnosis, past major illnesses, fractures, surgeries, etc. _____

B. Problems / Conditions (Please Check)

_____ constipation	_____ joint pain	_____ sinus problem	_____ headaches
_____ diarrhea	_____ falls	_____ foot care	_____ edema, location _____
_____ fever	_____ shortness of breath	_____ colds / flu	_____ other pain, location _____
_____ vomiting	_____ fainting	_____ chest pain / palpitations	_____ bleeding, location _____
		_____ urinary tract infections	_____ other, specific

C. Medications (list frequency & amounts)

D. Other Medical Treatments (Please check)

__ lab work, frequency _____	__ ostomy care	__ oxygen	__ dialysis	__ respiratory therapy	__ suctioning
__ ACCU check, frequency _____	__ dressings	__ IV's	__ transfusion	__ PT	__ Other _____
__ other _____	__ Speech	__ OT	__ Hx of TB		

E. Allergies: Y N Specify: _____

F. Height _____ Weight _____

G. Personal Physician: Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Applicant Name: _____

H. Prior stays in hospital or skilled nursing facility (list names of facility and dates).

IV. SELF CARE ABILITY / NEEDS (Please check)

GROOMING	<u>Independent</u> (No help is needed)	<u>Supervision</u> (needs reminding, overseeing, encouragement to complete thoroughly)	<u>Limited Assistance</u> (needs just physical help to guide or maneuver limbs.)	<u>Extensive Assistance</u> (needs another person to do part of the activity)	<u>Total Dependence</u> (needs another person to do activity completely)
Bathing					
Dressing					
Mouth Care					
Hair Care					
Shaving					

Does applicant resist care? Y N If yes, explain: _____

Overall, how many person are needed to perform self-care? _____

B. AMBULATION and TRANSFERS:

Able to walk: Y N Partially, explain: _____

Assistive devices used: cane wheelchair walker leg braces other: _____

Contractures: Y N Describe: _____

How much assistance is needed to get in and out of bed? _____

in and out of a chair? _____

on and off the toilet? _____

C. BOWEL and BLADDER CONTROL:

Bladder Control: Y N If no, frequency of incontinence: _____

Bowel Control: Y N If no, frequency of incontinence: _____

Is a foley catheter in place? Y N Type: _____ For how long?: _____

Is intermittent cathing needed? Y N If so, indicate frequency and level of assistance _____

Wears adult diapers for incontinence: Y N

D. SKIN INTEGRITY:

Are there skin problems? Y N

If so, what type:

- bed (pressure) sore Describe: _____
- rashes
- open areas
- surgical wound
- positive TB skin test
- other (specify) _____

Applicant Name: _____

E. NUTRITION AND DIET:

Able to eat: independently with some assistance with total assistance

If assistance is required, please explain: _____

Diet: Normal Special (describe: diabetic, soft, etc.) _____

Tube feeding: Y N If yes, give type, amount and frequency: _____

NG G

F. DENTAL / TEETH:

Natural / No problems Full Dentures Partial Dentures Upper Lower

Missing teeth

No Teeth

G. HEARING Adequate

Uses Aid

Minimal difficulty

Hears in special situations only

Highly impaired (absence of useful hearing)

H. VISION Adequate

Wears Glasses

Minimally impaired (Able to read large print)

Highly impaired

Blind

I. COMMUNICATION ABILITY:

Mode of expression: speech writing gestures / sounds communication device sign language

Speech clear: Y N No speech

Language spoken: English Other (specify): _____

Applicant is able to be understood: Always Usually Sometimes Rarely / Never

Applicant is able to understand others: Always Usually Sometimes Rarely / Never

J. MENTAL HEALTH HISTORY:

Does applicant have any history of mental retardation, mental illness or any other mental health problems: Y N

If yes, please explain: _____

Any history of:

anxiety or depression Y N

schizophrenia Y N

obsessive / compulsive disorder Y N

K. ACTIVITY:

Average time applicant is busy in a day: more than 2/3 of day
 between 1/3 and 2/3 of day
 less than 1/3 of day
 none

Types of activities that applicant is involved with _____

Prefers being with others: Y N

If no, explain: _____

Applicant Name: _____

Overall, will the applicant: improve deteriorate maintain over the next year

Interests / Hobbies (please list) _____

L. BEHAVIOR: (Please check):

Lack of motivation despite encouragement. Describe: _____

Frequent changes in mood. Describe: _____

History of an addiction. Specific: _____

Noisy / inappropriate expressions of distress. Describe: _____

Poor control of temper resulting in yelling or hitting at others or self.

Describe (type & frequency) _____

Restraints (such as medications, belt, fences, vests, special chairs, etc.) are used to control behavior or wandering.

Describe: _____

None of the above.

M. COGNITION (Please indicate % of time with a check “✓”)

How much of the time does the applicant:	100%	75%	50%	25%	0%
Recognize family members / friends by name?					
Have good short term memory? (Able to recall events that happened a few hours ago.)					
Have good long term memory? (able to recall events that happened months or years ago.)					
Make social conversation?					
Recognize and identify his / her surroundings					
Have a concept of time?					
Reason and think logically and appropriately?					
Good judgment related to safety and abilities?					

After completion please return application to: Admissions Department
at St. Francis Health Care Centre, 401 N. Broadway Street, Green Springs, OH 44836 or fax to 419-639-6222.

Thank You.