HAZEL FINDLAY - 989.224.8936
1101 S. Scott Rd. - St. Johns, MI 48879
Continuing Care Close to Home

APPLICATION FOR ADMISSION

To ensure accurate information has been obtained, please fill in ALL of the blanks.

GENERAL INFORMATION				
Date:		Social Security #:		
Name:	DOB:	Age:	_____ Male _____ Female	
Medicare #:		Medicaid #:		
Current Address:		City:	State:	

Primary Physician:_____ Phone #:_____ Other Physician(s):_____ Phone #:_____	Filled out by: Individual:_____ Agency:_____ Phone #:_____
Reason(s) patient is requesting admission: _____ _____ _____ _____ _____ _____ _____	Alternate Decision Maker: _____ None _____ Guardian _____ Power of Attorney (Health Care) _____ Power of Attorney (Financial) _____ Living Will Name: _____ Relationship:_____Phone #:_____

EMERGENCY/FAMILY CONTACT:		
Name & Relationship	Telephone	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL / INSURANCE		
Type of Insurance: _____ Medicare _____ Medicaid _____ BCBS _____ Other (List below) _____ _____	Income/Assets (Estimated Amount): Social Security:_____ Checking:_____ Savings:_____ Pension:_____ Other:_____	Real Estate: Estimated Value:

None = no assistance needed / Minimal = supervision / Moderate = 1 person assistance Extensive = 2+ person assistance / Total = mechanical lift		
Eating Meals Identify the level of assistance needed to perform the activity of feeding and eating	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**
Toileting Identify the resident's ability to get to and from the toilet, and care for own needs	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**
Ambulation Identify the resident's physical ability to get around, both inside and outdoors (list mechanical aids if needed)	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**
Transferring Identify the resident's ability to transfer from chair or bed	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**
Personal Hygiene: Identify the resident's ability to maintain personal hygiene, (shave, care for mouth, comb hair, etc.)	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**

Dressing Identify the resident's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**
Housekeeping Identify resident's ability to attend to housekeeping tasks (making bed)	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**
Night Needs Identify resident's need for assistance at night and/or nightly checks	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**
Recreational/Social Activities Identify the resident's ability and/or willingness to participate in activities	**Assistance Required** _____ None _____ Minimal _____ Moderate _____ Extensive _____ Total	**Comments/Equipment Used:**

Check one answer for each question below.	
Wandering: moving about aimlessly; wandering without purpose or regard to safety. _____ Does not wander. _____ Wanders within the residence or facility and may wander outside but does not jeopardize health or safety. _____ Wanders within the residence or facility. May wander outside; health or safety may be jeopardized, but resident is not combative about returning and does not require professional consultation and/or intervention. _____ Wanders outside and leaves immediate area. Has consistent history of leaving immediate area, getting lost, or being combative about returning. _____ Requires constant supervision, behavioral management, intervention, and/or professional consultation.	**Comments:**
Combative behavior: combative to others (throws objects, strikes or punches, bites, scratches, kicks, makes dangerous maneuvers, destroys property, etc.) _____ Is not combative or dangerous. _____ Is sometimes combative. Requires special tolerance or management, but does not require professional consultation and/or intervention. _____ Is frequently combative, and may require behavioral management, intervention and/or professional consultation. _____ Is combative, and requires constant supervision, behavioral management, intervention and/or professional consultation.	**Comments:**
Danger to self: indicated by self-neglect, suicidal thoughts, suicide attempts etc. _____ Does not display self-injurious behavior. _____ Displays self-injurious behavior but can be redirected away from those behaviors. _____ Displays self-injurious behavior, and behavioral control intervention and/or medication may be required to manage behavior. _____ Displays self-injurious behavior and requires constant supervision with intervention and/or medication.	**Comments:**
Self-preservation: ability to avoid situations in which he/she may be in danger. _____ Physical and judgmental ability to take appropriate action in emergency situations. _____ Is clearly aware of surroundings, able to discern and avoid situations in which he/she may be in danger, and physically capable of self-preservation and/or evacuation in emergencies. _____ Is able to discern situations in which he/she may be in danger but due to physical limitations may need some assistance to self-preserve or evacuate _____ Is frequently confused and unable to discern and/or avoid situations in which he/she may be in danger and needs guidance and assistance. _____ Requires constant supervision due to his/her inability to self-preserve.	**Comments:**

MEDICATIONS

_____ Resident will self administer medication _____ Needs medication administration

_____ Total number of medication prescribed

Any known allergies? _____ Yes _____ No

If yes, please list: _____

_____

Names/Dosage:	Frequency:

Comments regarding medication use:

Does resident use any over the counter medications, supplements, or home remedies?

If yes, please list: _____

_____

Current Medical Diagnoses: (please list)

Current Mental Health Diagnoses: (please list)

Other Problems: (please explain)

Cardiological: _____

Respiratory: _____

Gastrointestinal: _____

Neurological: _____

Muscular/skeletal: _____

Skin: _____

Substance Abuse: _____

History of Falls: (Check One)

_____ None
_____ Some
_____ Frequent

Sleep Habits and Problems: (please explain)

Bladder Control: (Check one)

_____ Continent
_____ Occasional Incontinence
_____ Frequent Incontinence
_____ Total Incontinence
_____ Catheter

Bowel Control: (Check one)

_____ Continent
_____ Occasional Incontinence
_____ Frequent Incontinence
_____ Total Incontinence
_____ Ostomy

Current Therapies/Treatments:

_____ None
_____ Physical Therapy
_____ Occupational Therapy
_____ Speech Therapy
_____ Respiratory Therapy
_____ Wound Clinic -How often and what clinic? _____
_____ Lymphedema Clinic -How often and what clinic? _____
_____ Dialysis Center -What days/time and what center? _____

Oxygen:

_____ Yes
_____ No
If yes, how many liters?
_____

COVID Vaccinated:

_____ Yes
_____ No
If yes, how many shots/ boosters? _____

Vision: (with glasses if used)

_____ Adequate
_____ Impaired
_____ Severely impaired
_____ Blind

Hearing: (with hearing aid if used)

_____ Adequate
_____ Impaired
_____ Severely impaired
_____ Deaf

Communication:

Primary Language: _____

Able to: (Check all that apply)

_____ Understand
_____ Speak
_____ Read
_____ Write

Diet Information:

Currently on special diet ordered by physician? _____ Yes _____ No
Is patient following the prescribe diet? _____ Yes _____ No

Please specify diet type:

_____ Low fat
_____ Restricted sodium
_____ Diabetic
_____ Lactose intolerance
_____ Liquid
_____ No restrictions
_____ Liquid
_____ Kidney friendly
_____ Carb Control
_____ High Protein
_____Regular diet with added nutrients
_____ Other - please explain: _____

Height: _____
Weight: _____
Appetite: _____

Potential Diet Problems: (please check one)

Yes	No	
_____	_____	Does patient have mouth or tooth problems that make it hard to chew?
_____	_____	Has patient gained or lost ten or more pounds in the last six months without wanting to?
_____	_____	Is patient able to feed them self?
_____	_____	Does patient have difficulty swallowing?
_____	_____	Does patient have nausea/vomiting?
_____	_____	Does patient have heartburn/reflux?