**HATTIE IDE CHAFFEE**

**PREADMISSION INFORMATION**

**Date:**

**Legal Name:**

**D.O.B.**

**Address: Phone #:**

**City/Town: State: Zip Code:**

**Marital Status: Religion:**

**Prior Occupation:**

**MEDICAL COVERAGE**

**Medicare Number: Other Insurance: Type**

**Part B Yes No Number**

**Please provide copies of Medicare card, Insurance card & Social Security card when returning this form.**

**RESPONSIBLE PARTIES**

**NAME: Relationship:**

**ADDRESS: Phone: CITY/TOWN: STATE: ZIPCODE:**

**NAME: Relationship:**

**ADDRESS: Phone: CITY/TOWN: STATE: ZIPCODE:**

|  |  |  |
| --- | --- | --- |
| **FINANCIAL INFORMATION****PRIVATE:** | **Yes** | **No** |
| **Estimated Time Private pay:** **Long Term care Insurance:** | **Yes** | **No** |
| **Medicaid:** | **Yes** | **No** |
| **If YES, has applicant been started?** | **Yes** | **No** |

**Social Security Amount: Other Income:**

**MEDICAL INFORMATION**

**Medical Diagnoses:**

**PHYSICIAN: Height: Weight:**

**Recent Hospital Admission dates: Reason:**

**Prior Nursing Home Admissions: Yes No Dates: From To**

**Medications:**

|  |  |  |
| --- | --- | --- |
| **Do you have a durable POA for Health care?** | **Yes** | **No** |
| **Do you have a Living Will?** | **Yes** | **No** |
| **History of falls:** | **Yes** | **No** |
| **Walker:** | **Yes** | **No** |
| **Cane:** | **Yes** | **No** |
| **Wheelchair:** | **Yes** | **No** |

**Skin Integrity: OXYGEN in use: Yes No**

**Smoking: Yes No**

**Alcohol: Yes No**

**\*\*\*\*\*\*\* Please Note: *HATTIE IDE CHAFFEE* IS A NON-SMOKING FACILITY \*\*\*\*\*\*\*\***

|  |  |  |
| --- | --- | --- |
| **Verbal/Physical Aggression:** | **Yes** | **No** |
| **Wandering:** | **Yes** | **No** |
| **Calling Out:** | **Yes** | **No** |
| **Psychiatric History (i.e.; depression, Bipolar, Schizophrenia)** | **Yes** | **No** |
| **Hospital Admission for above:****Date:**  | **Yes** | **No** |
| **Funeral Home:** **Phone:**  |  |  |

**Address:**

**PLEASE PROVIDE ANY INFORMATION YOU FEEL WOULD BE HELPFUL IN CARING FOR YOUR LOVED ONE:**

**Person Completing this form: Date:**

**Relationship:**

**Email**