ADMISSION RECORD

Date of contact: _____ Physician: _____

Resident Name: _____ M / F

DOB: _____ Age: _____ M Status: _____

Address: _____ Phone: _____

Current Placement: _____ Phone: _____

Mobility: _____ Ind _____ Bed mobility _____

W/C _____ Transfer _____

Walker _____ Toileting _____

Cane _____ Eating _____

DX _____

Date of last I V fluids _____ Last I V Meds _____

Date of Last 02 use _____ Date of last transfusion _____

Infection _____ Antibiotic _____

Catheter _____ Ostomy _____

Tube Feeding _____ Diabetic _____ Diet _____

Allergies _____ Therapies received/needed _____

Falls _____ Dizziness _____ Visual deficits _____

Balance or Gait problems: _____Y _____N Able to call for help? _____

Anticipated Discharge Date: _____

Dr. order for admit: _____ HXP: _____

Admit Date: _____ Admit Nurse: _____

Medical #: _____ Room #: _____ Private room (requested) _____

DD/MR _____ Level 2 needed _____ Prescreen Date: _____

FINANCIAL INFORMATION

Social Security #: _____

Medicare #: _____ Part A Part B

Primary_____ Secondary_____ Medicare Days Used? _____

MA #: _____

HMO Name: _____ Policy#: _____

Preauthorized required Yes No

Insurance Co. Name: _____ ID#: _____

Policy Holder Name: _____ Policy#: _____

Group #: _____

Private Pay: _____

Medicare Days Available: _____ Used: _____

Qualifying Hospital Date: _____

Placement last 30 days: _____ Last 60 days: _____

RTA: _____ TV: _____ POA: _____ LW: _____

Billing to: _____

FAMILY CONTACTS:

Name: _____

Address: _____

Phone: _____

ADDITIONAL CONTACTS

Pharmacy: _____

Dentist: _____

Optometrist: _____

Funeral Home: _____

SERVICES PRIOR TO HOSPITALIZATION _____ None _____ Housekeeping _____ Meals on Wheels

_____ Home Care _____ Lifeline _____ Other Services

_____ CADI _____ EW _____ ACG