

RE: \_\_\_\_\_

DATE REC'D: \_\_\_\_\_

LTC: \_\_\_\_\_

(for office use only)



**D'YOUVILLE**

SENIOR CARE

*Serving the Community with Compassion*

**APPLICATION FOR ADMISSION**

## APPLICATION FOR ADMISSION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Location: Home Hospital Other \_\_\_\_\_ Date of Admission: \_\_\_\_\_

If Hospital, Case Manager's Name: \_\_\_\_\_

Inquiry made by: \_\_\_\_\_ Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F Birthdate: \_\_\_\_\_ Religion: \_\_\_\_\_

Marital Status: M S W D Parish/Congregation \_\_\_\_\_

Former Occupation: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Are you seeking: Long Term Care Short Term Care

Contact (1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Contact (2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Health Care Proxy Agent: \_\_\_\_\_ Power of Attorney \_\_\_\_\_

Conservator \_\_\_\_\_ Guardian \_\_\_\_\_

Method of Payment: Private \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Other \_\_\_\_\_

Social Security # \_\_\_\_\_ Other \_\_\_\_\_

Medicare # \_\_\_\_\_ Part A \_\_\_Yes\_\_\_No Part B \_\_\_Yes\_\_\_No

Other Insurance \_\_\_Yes\_\_\_No Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Phone # \_\_\_\_\_ Type of Coverage \_\_\_\_\_

Patient's Diagnosis / Medical Problems: \_\_\_\_\_

\_\_\_\_\_

Please list patient's medications: \_\_\_\_\_

\_\_\_\_\_

Patient's Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**PATIENT CARE INFORMATION:**

Does patient feed self? \_\_\_\_\_

Does patient walk? \_\_\_\_\_ Independent \_\_\_\_\_ Assist \_\_\_\_\_

Walker \_\_\_\_\_ Cane \_\_\_\_\_ Not at all \_\_\_\_\_

Does patient need assist with the following: Bathing \_\_\_\_\_

Dressing \_\_\_\_\_ Toileting \_\_\_\_\_ Transfers \_\_\_\_\_

Is patient continent? Bladder \_\_\_\_\_ Bowel \_\_\_\_\_

Describe patient's skin condition

\_\_\_\_\_

Any open areas on skin: \_\_\_\_\_

Does patient have any communicable diseases? \_\_\_\_\_

\_\_\_\_\_

Does patient have any diet restrictions or special preferences? \_\_\_\_\_

\_\_\_\_\_

Describe patient's vision and hearing: \_\_\_\_\_

Describe patient's speech: \_\_\_\_\_

Does patient have any sleep disturbance? \_\_\_\_\_

Does patient have any problem with pain? \_\_\_\_\_

Is patient alert: \_\_\_\_\_ Oriented to person \_\_\_\_\_ Place \_\_\_\_\_ Time \_\_\_\_\_

Is patient aware of request for placement: \_\_\_\_\_

Behavior

Withdrawn \_\_\_\_\_ Noisy \_\_\_\_\_ Cooperative \_\_\_\_\_ Anxious \_\_\_\_\_

Agitated \_\_\_\_\_ Strike out at others: \_\_\_\_\_ Depressed \_\_\_\_\_

Does patient have any history of emotional/mental disorders? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe patient's daily routine:

\_\_\_\_\_

\_\_\_\_\_

**FINANCIAL RESOURCES**

PENSION AMOUNT (PER MONTH): \_\_\_\_\_ \$ \_\_\_\_\_  
SOCIAL SECURITY AMOUNT (PER MONTH): \_\_\_\_\_ \$ \_\_\_\_\_  
OTHER INCOME AVAILABLE: \_\_\_\_\_ \$ \_\_\_\_\_  
ASSETS AVAILABLE FOR PATIENT'S CARE: \_\_\_\_\_ \$ \_\_\_\_\_

FINANCIALLY RESPONSIBLE PERSON: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

PLEASE DISCLOSE ANY ADMISSIONS/CONFINEMENTS TO ANY OTHER HEALTHCARE FACILITIES  
IN THE 12 MONTHS.

FACILITY NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
FACILITY NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*INSURANCE INFORMATION INCLUDING COPIES OF ALL INSURANCE CARDS MUST BE  
PROVIDED TO D'YOUVILLE PRIOR TO ADMISSION.**

**981 Varnum Avenue  
Lowell, MA 01854  
978-569-1000; Fax: 978-569-1084**

D'Youville Senior Care does not discriminate on the basis of race, color, national  
origins, handicap or age in our admission policy. This is in accordance with Law  
and Regulations:

Title VI of the Civil Right Act 1964 45 CFR part 80  
Section 504 of the Rehab Act 1973 45 CFT part 84  
Age Discrimination Act 1975 45 CFR part 91