ROBERTS HEALTH CENTRE
PREADMISSION INFORMATION

Date: _____

Legal Name: _____ **D.O.B.** _____

Address: _____ **Phone #:** _____

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

Marital Status: _____ **Religion:** _____

Prior Occupation: _____

MEDICAL COVERAGE

Medicare Number: _____ **Part B Yes** ☐ **No** ☐

Other Insurance: Type _____ **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: *Roberts Health Centre* IS A NON-SMOKING FACILITY ********

Behaviors:

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: **Yes** ☐ **No** ☐

Date: _____

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