MOUNT VERNON NURSING & REHABILITATION CENTER

PRE~ADMISSION INFORMATION

PLEASE COMPLETE AND RETURN TO MVNRC NO LATER THAN ONE DAY PRIOR TO ADMISSION. THANK YOU!

Resident's Name:______________________ Social Security Number:______________________

Address:______________________ Home Phone:______________________

City:______________ State:______________ Zip:______________

Sex:__________ Race:______________ Birth Date:______________

Birthplace:______________________ Religion:______________________

Occupation:____

Marital Status: S M D W Spouse's Name:______________________

Medicare Number:______________________ Medicaid Number:______________________

Secondary Insurance Carrier:______________________ ID Number______________________

Resident's Diagnosis:____

____

Primary Care Physician:______________________ Phone:______________________

Will Physician follow at this facility? ❑ YES ❑ NO

Funeral Home Preference:______________________ Phone:______________________

Is there a Power of Attorney: ❑ YES ❑ NO Legal Guardian: ❑ YES ❑ NO

Durable Power of Attorney for Health Care: ❑ YES ❑ NO Living Will: ❑ YES ❑ NO

Responsible Party For Paying Expenses While At MVNRC:

Name:______________________ Relationship:______________________

Address:____

City:______________ State:______________ Zip:______________

Home Phone:______________________ Work Phone:______________________

Email Address:______________________ Social Security Number:______________________

PERSONS TO NOTIFY IN CASE OF EMERGENCY:

Name:______________________ Relationship:______________________

Address:____

City:______________ State:______________ Zip:______________

Home Phone:______________________ Work Phone:______________________

Email Address:______________________

Name:______________________ Relationship:______________________

Address:____

City:______________ State:______________ Zip:______________

Home Phone:______________________ Work Phone:______________________

Email Address:______________________

PRE~ADMISSION INFORMATION

The following information could be of great importance to you. Please read and consider when answering the following questions below.

In a Skilled Nursing Facility, Medicare benefits or private insurance benefits are **ONLY** applicable to rehabilitation.

If, after a skilled rehabilitation stay, a resident continues to need care in a Nursing Facility, it is considered Long Term Care.

Long Term Care is paid for either with private funds, Long Term Care Insurance or through the Medicaid Program.

Mount Vernon Nursing and Rehabilitation Center has a financial requirement for admission to Long Term Care. A consultation with the Director of Admissions is necessary to discuss specific requirements and availability. In addition, the Director of Admissions will provide you with the *Room Rates and Charges* sheet in order to estimate the annual cost.

With this information in mind, please answer the following questions:

Is the Resident here for short-term rehabilitation or respite care?

____

Is the Resident in need of Long Term Care presently or in the near future?

❑ YES ❑ NO

If NO – please sign the bottom of this form. If YES, please continue.

Does the Resident have sufficient funds for Long Term Care?

❑ YES ❑ NO

In the space below, please explain the nature and estimated amount of funding available. We do not ask for specific account information in regard to exact numbers, instead, we rely on good faith. However, if the information proves to be incorrect, the Resident would become ineligible to be admitted to a Medicaid funded bed in this facility.

____

____

____

____

(PRINT) Resident Name______________________________ Date:____________

______________________________ ______________________________ ____________

Signature of Person Completing Form Relationship Date

MOUNT VERNON NURSING & REHABILITATION CENTER

PRE~ADMISSION INFORMATION

RESIDENT'S NAME:________________________________ **PREFERS TO BE CALLED:**________________________________

LIVED ALONE PRIOR TO ENTRY: **YES** **NO** **ZIP CODE OF PRIOR PRIMARY RESIDENCE:**____________

BORN & RAISED:________________ IF FOREIGN BORN ~ AGE CAME TO USA:_______ **CITIZEN NOW?** **YES** **NO**

NUMBER OF CHILDREN: BOYS________ GIRLS________ GRANDCHILDREN________

SURVIVING CHILDREN, PRESENT RELATIONSHIPS AND AMOUNT OF CONTACT: ________________________

____

LIFETIME OCCUPATION(S):____

EDUCATION:____________________________________ **PRIMARY LANGUAGE:**______________________________

RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY:
(CHECK ALL SETTINGS RESIDENT LIVED IN DURING 5 YEARS PRIOR)

( ) PRIOR STAY AT THIS NURSING HOME

( ) STAY IN OTHER NURSING HOME

( ) OTHER RESIDENTIAL FACILITY ~ BOARD & CARE HOME / ASSISTED LIVING / GROUP HOME

( ) MENTAL HOSPITAL ~ PSYCHIATRIC SETTING

( ) MENTAL RETARDATION ~ DEVELOPMENTALLY DISABLED SETTING

( ) **NONE OF ABOVE**

DISCHARGE POTENTIAL:

RESIDENT EXPRESSES ~ INDICATES PREFERENCE TO RETURN TO THE COMMUNITY **YES** **NO**

RESIDENT HAS A SUPPORT PERSON WHO IS POSITIVE TOWARD DISCHARGE **YES** **NO**

IN THE EVENT RESIDENT IMPROVES SUFFICIENTLY TO BE DISCHARGED, THE TENTATIVE PLAN IS FOR RESIDENT TO GO TO:

( ) OWN HOME

( ) RELATIVE'S HOME

( ) ASSISTED LIVING COMMUNITY

( ) ANOTHER NURSING FACILITY

HAS RESIDENT HAD TUBERCULOSIS: **YES** **NO**

HAS RESIDENT HAD POSITIVE TB SKIN TEST:
YES **NO**

HAS RESIDENT HAD FLU VACCINE: **YES** **NO**
DATE:______________________________

HAS RESIDENT HAD PNEUMOVAX: **YES** **NO**
DATE:______________________________

LIST ANY KNOWN MEDICATION ALLERGIES:

____

LIST ANY KNOWN FOOD ALLERGIES:

____

LIST ANY KNOWN FOOD DISLIKES:

____

LIST FAVORITE FOODS:

____

BEVERAGE PREFERENCES:

____

PROBLEMS WITH CHEWING, SWALLOWING OR APPETITE: **YES** **NO**

IF YES, STATE REASON:

____

PRE~ADMISSION INFORMATION

RESIDENT'S NAME________________________________ AGE__________

ADMISSION FROM________________________________

Prior to hospitalization could resident walk?________________________________

Did resident need any human or mechanical help to walk?________________________________

Check the type of assistance the resident needed:

personal assistance_____ cane_____ walker_____ holding furniture or rails_____

Before hospitalization could resident stand up without help?________________________________

Could resident sit down without help?________________________________

Did resident wander away from safe area?________________________________

Has resident fallen in the past 30 days?________ past 31~180 days________

How did the fall happen?________________________________

Was the resident injured in the fall?________________________________

Prior to hospitalization did resident complain of pain? Daily______ Less than daily______

Pain site________ Mild pain________ Moderate pain________

Is resident on a pain management program? ❑ YES ❑ NO

List pain medication:________________________________

____

____

________________________________ ________________________

Signature: Date

____

Relationship to Resident