

Resthave Home

408 Maple Avenue, Morrison, IL 61270
Phone: 815-772-4021 Fax: 815-772-4583

PRE-ADMISSION FORM

Date: _____ Person completing form: _____ Relationship: _____

Person completing form's number(s) _____

Placement desired: _____ Assisted Living _____ Nursing (informational sheet attached)

Applicant's full name: _____

Applicant's home address: _____

Applicant's phone number(s): _____ U.S. Citizen? ___ No ___ Yes

Presently residing: ___ Hospital ___ Home ___ Assisted Living ___ Nursing Home

___ Other (please specify): _____

Birth date: _____ Age: _____ Marital status: M W S D

Social security #: _____ Medicare #: _____

Medicaid #: _____

MEDICAL INFORMATION \ CONDITION

Physician: _____ Approximate date of last visit: _____

Any specialist seen routinely or currently seeing: _____

Diagnosis: _____

Known allergies: _____

History of major surgeries / medical conditions: _____

Recent hospitalizations: ___ No ___ Yes, please list what for: _____

Current medications: (please list) _____

Summary of why seeking placement at this time: _____

What areas does the applicant need assistance in? _____

Prone to wander: No Yes Any falls in the last 6 months: No Yes, date of last fall: _____

Prone to become verbally aggressive: No Yes, please explain: _____

Prone to become physically aggressive: No Yes, please explain: _____

Past conviction of felony, sex offense or inappropriate sexual behavior? No Yes, please explain: _____

Any history of mental illness? No Yes, please explain: _____

DECISIONS

Has the individual participated in the decision to come to this facility? No Yes

Is there a Living Will? No Yes

Durable Power of Attorney for Health Care? No Yes

Power of Attorney for Finances? No Yes

A member of the admissions team will contact you following completion of this form to set up an assessment.