MONROE COMMUNITY HOSPITAL
435 EAST HENRIETTA ROAD
ROCHESTER, NEW YORK 14620
760-6024 or 760-6025 FAX# 760-6026

PRE-ADMISSION RECORD
APPLICANT:

Last	First	M	Sex	D.O.B.	Social Security #

Race	Marital Status	Veteran Y ❑ N ❑	US Citizen? Y ❑ N ❑ Spanish/Hispanic Origin? Y ❑ N ❑	Spouse's Name

Address	City	State	Zip Code	County	Phone #

Religion/Parish	Primary Language	Birth Place: Do you have a birth certificate: Yes ❑ No ❑	Is applicant participating in an anatomical gift program? Y ❑ N ❑

Applicant lived alone? Y ❑ N ❑ Another Facility?	Mother's Name: (Maiden) Living Y ❑ N ❑	Father's Name: Living Y ❑ N ❑

Applicant's Lifetime Occupation/Employer		Spouse's Occupation/Employer	
Employer's Address/Phone#	Date of Retirement or Disability	Employer's Address/Phone #	Date of Retirement or Disability

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EMERGENCY CONTACTS

Name		Relationship	
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	

Power of Attorney? Y ❑ N ❑ Health Care Proxy? Y ❑ N ❑ Living Will? Y ❑ N ❑ Guardian? Y ❑ N ❑

Please provide copies of any applicable documents including copies of all insurance cards

Name		Relationship	
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	

Power of Attorney? Y ❑ N ❑ Health Care Proxy? Y ❑ N ❑ Living Will? Y ❑ N ❑ Guardian? Y ❑ N ❑

Please provide copies of any applicable documents including copies of all insurance cards

WE DO NOT DISCRIMINATE ON THE BASIS OF RACE, AGE, COLOR, NATIONAL ORIGIN, SEX, DISABILITY, MARITAL STATUS, SEXUAL ORIENTATION, RELIGION, SOURCE OF PAYMENT OR SPONSORSHIP.

EMERGENCY CONTACTS (continued)

Name		Relationship	
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	

Power of Attorney? Y ❑ N ❑ Health Care Proxy? Y ❑ N ❑ Living Will? Y ❑ N ❑ Guardian? Y ❑ N ❑

Please provide copies of any applicable documents including copies of all insurance cards

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PRE-ADMISSION INSURANCE INFORMATION

MEDICARE #	Part A: Part B:
PART D PLAN	PART D POLICY #

MEDICAID CIN #:	County:	Pending? Y ❑ N ❑
If pending, please advise appointment date:	Worker:	Phone #:

PREFERRED CARE #:	**PREFERRED CARE GOLD** #:

P/KEHC#	**P/C KODAK #**

BLUE CHOICE #	**BLUE CHOICE SENIOR** #

CHOICE CARE # _____

BLUE CROSS #:	Plan	Type	Group

OTHER INSURANCE	Name:	Policy #:
Billing Address		Phone #:

List all prior stays, beginning with most current: (Include any Skilled Nursing Facility And Hospital Stays:)

Dates (From/To)	Location	Dates (From/To)	Location

Is this admission a result of a *motor vehicle* related accident? Yes ❑ No ❑

Motor Vehicle Accident (Please check one) Was the applicant the: Driver ❑ Passenger ❑ Pedestrian ❑	
Accident date and time:	
Detail of accident including location:	
Owner of Vehicle:	Driver of Vehicle:
Subscriber's Name:	Policy #:
No-Fault Insurance Company:	Phone #:
Address:	Agent/Claim Rep: Claim #:

Is this admission a result of a *work related* accident? Yes ❑ No ❑

Work Related Compensation	
Employer:	Phone #:
Address:	
Insurance Carrier:	Worker Comp Benefit #:

Is this admission a result of *any* accident? (i.e. fall any place) Yes ❑ No ❑ Date of accident:_____

Where did the fall happen? (ie - Home, Mall, etc.)
Address where the fall occurred:

PRE-ADMISSION FINANCIAL STATEMENT

Source	Applicant	Spouse	Address where check is sent
Social Security			
Private Pension*			
RR Retirement, SSI, Veteran			
Other			
TOTAL Monthly Income			

*Source & Address of Pension:

B. Liquid Assets

Liquid Assets (include all checking or savings accounts, as well as CDs, IRS's, Annuities, Mutual Funds, Life Insurance that can be converted to cash, or any other investments that can be turned into cash)

Information is to include all of assets of applicant and spouse

Types of Accounts (ie Savings, Checking, CD, etc.)	Bank	Current Value
a.		
b.		
Life Insurance? Y ❑ N ❑ Term ❑ Whole Life ❑ Cash Value ❑ Death Benefit ❑		
Trust Accounts? Y ❑ N ❑ Established Date: Irrevocable? Y ❑ N ❑		
	TOTAL LIQUID ASSETS	

C. Real Estate Assets (List all property that is in the applicant and/or spouse's name. If none, please indicate "none")

Property Address	Mortgage Balance - Name of Mortgage(s)	Current Value
	TOTAL REAL ESTATE VALUE	

Has the applicant disposed of any assets in the past five years? Y ❑ N ❑
If yes, state to whom, the value(s)/amount(s) and date(s):
Any children residing with Applicant? Yes ❑ No ❑ If yes, how long have they resided there?

Form Completed By:_____ Relation to Applicant:_____

MEDICAL INFORMATION FORM

Comprehensive medical information is part of the review process. This information can be provided by a detailed medical summary furnished by the physician or by the physician completing, signing and dating this form.

Patient's Name _____ Date of Birth _____

Primary Diagnosis: _____
Secondary Diagnoses: _____
_____

Reason for Admission: Admission is requested as patient is in need of:

_____ Rehabilitation _____ Long Term Care _____Dementia _____Respite

Current Findings:
Is the patient free of infectious disease? _____Yes ____No If no, indicate problem and current treatment: _____
_____
_____

Does the patient have an active drug, tobacco, or alcohol dependency or history?
____Yes ____ No
If yes, please explain problem and current treatment: _____
_____
_____

Other pertinent physical findings: _____
_____
_____

Weight: _____ Height: _____ Diet: _____

Are there any swallowing problems? ____ Yes ____ No _____ Unknown
If yes, please explain: _____
_____

Allergies: _____
_____

Current Medications

Name	Dose	Route	Frequency

Health Maintenance

	Yes	No	Date / Results
Flu Vaccine			
Pneumonia Vaccine			
Diphtheria/Tetanus Vaccine			
Tuberculin Skin Test			Results
PAP Smear			Results

Functional Status (please enter, Yes, No, or Unknown as indicated)

Mental (What mental traits does this patient manifest?)

	Yes	No	Unknown		Yes	No	Unknown
Memory Loss				Impaired Judgement			
Agitation				Disorientation			
Depression				Hallucinations			
Verbal Disruption				Physical Aggression			
Wandering				Psychosis			

Are the traits of such severity that the patient is/could be harmful to self or others?
_____Yes _____No

Does the patient have history of psychiatric hospitalization(s) or professional treatment?
_____ Yes _____No If yes, please explain: _____

Does the patient present special management needs? _____Yes _____ No
If yes, please explain: _____

Does the patient exhibit any social inappropriate behavior? _____Yes ____No
If yes, please explain: _____

Sensory: (Is impairment of the following special senses of significant severity as to contribute to the patient's disability?)
Eye Sight: _____Yes _____No Hearing: _____Yes _____No
Speech: _____Yes _____No
(If aphasic, indicate: receptive, expressive or mixed): _____

Incontinence: (Does the patient have…?)
Bladder incontinence _____Yes ____No Bowel incontinence ____Yes ____No
Catheter _____Yes ____No Ability to self-manage: ____Yes ___No
Type: _____

Weight-Bearing Status: (Please indicate present status)
Full _____Yes ____No Partial _____Yes ____No (Right)
Non-Weight bearing _____Yes _____No Partial _____Yes ____No (Left)

Ambulatory Status: (Please indicate present status)
Complete bed rest ____ Yes ____No Bed/Chair status ____Yes ____No
Ambulatory with assistance _____Yes ____No Assistances _____ #s____
Ambulatory with device _____Yes ____No Devise used: _____
Independent ambulation _____Yes ____No

Laboratory Data (Please include copies if available)

Laboratory Data	Date	Results
Last chest x-ray		
Last urinalysis		
Last EKG		
Last blood work		
Thyroid function tests		

Physician's Signature _____ Date _____
Name of Physician _____ Telephone: _____
Address: _____

SOCIAL SUMMARY

The following information is needed to make a determination of appropriateness of placement.

Height: Weight: Does the applicant wander? Yes ___ No ___
Is the applicant noisy? Yes ___ No ___ If yes, please describe (i.e. – during a certain time of day/night, during personal care, etc.)
How does the applicant respond to personal care?
Describe applicant's sleep pattern:
How does the applicant feel about nursing home placement?
Describe applicant's family/friend support network:
Why is family/applicant seeking nursing home placement?
What is the possibility of a return home or alternative placement?
Comments:

Name of person completing form:_____

Relationship to applicant: _____

Phone number: _____ Date: _____