PRE ADMIT FORM

Luther Manor *3131 Hillcrest Road* *Dubuque, IA 52001-3999*
Phone: 563)588-1413 *Fax # (563)588-3875*

Name:____
(Last Name) (First Name) (Middle Initial)

Address__________________________ City____________ State_____ Zip _________
Telephone ( ) ______________________ Cell phone # ( )_________________

How long at this primary address?________________
Present placement: ____ Hospital ____Assisted Living _____, Skilled Facility,
Other ___________________

Card Information Needed:
Medicare # _____________________ Social Security # ____________________
Medicaid # (if on T19) #__________________

Supplemental Insurance Co. ______________________ Phone ________________
Policy # __________________ Address: _________________________________

Pharamacy Part D Co. _______________________ Policy # _________________
Group # ____________ Present pharmacy ________________________

Front and back copies of your cards from Medicare, Social Security,Medical Supplemental Insurance and Pharmacy Part D cards will be needed with this pre-admit. We would be glad to make the copies for you.

Veteran Information:: Veteran's name (resident/spouse) ________________________________
Branch of Service _____________ Entered ________ Discharged _______ War _________
Is the veteran/spouse currently receiving any VA monetary benefits? Monthly amt.$_______
Currently receiving VA Medical Benefits? _____ Prescription ______ Dr. treatment

PERSONAL HISTORY

Birth date _____________ Birthplace _________________ Raised at _______________
Education________________________ Occupation(s) __________________________
Name of Spouse(s) ___________________________Occupation __________________
Date of Marriage _________________ Date if deceased ______________
List their children in birth order and where they live:

1. ______________________________ City, State ____________________
2. ______________________________ City, State ____________________
3. ______________________________ City, State ____________________
4. ______________________________ City, State ____________________
5. ______________________________ City, State ____________________

6. ______________________________ City, State ____________________
7. ______________________________ City, State ____________________
8. ______________________________ City, State ____________________
9. ______________________________ City, State ____________________

Resident's Father's Name ___________________ Died _________ Occupation _____________
Mother's Maiden Name _____________________ Died _________ Occupation _____________
Siblings: List in order of birth/ where they lived/ when died:
____
____

Religion _________________________ Church ____________________________
Address ____
Clergy ___________________________ Phone _________________________

MEDICAL

Primary Physician ____________________________ Phone ________________________
Dentist ____________________________ Phone ________________________
Optometrist _________________________ Phone ________________________
Podiatrist ___________________________ Phone ________________________
Psychiatrist _________________________ Phone ________________________
Hospital ________________________

LIST ALL HOSPITAL STAYS IN THE LAST SIXTY DAYS

Hospital ____________________________ Dates on Acute care ___/___/___ to ___/___/____
Dates on Skilled Care, if any: ___/___/___ to ___/___/___ Facility: _________________
Hospital ____________________________ Dates on Acute care ___/___/___ to ___/___/____
Dates on Skilled Care, if any: ___/___/___ to ___/___/___ Facility: _________________

History of Major Operations/Medical Problems
____
____

Funeral Home ________________________ City ______________ Phone _________________
Is there an Irrevocable Burial Trust established with the funeral home? _____ Yes _____ No

DOCUMENTATION

Emergency Contact Person(s): _________________________ (Be sure to put them on the contact list)
Has the resident made out the following documents?
A Living Will? Yes _____ No _____
A Durable Power of Attorney for Medical Decisions? Yes _____ No _____
If yes, who is named responsible for decisions?________________________
A Power of Attorney (for finances)? Yes _____ No _____
If yes, who is named the responsible party? __________________________
(If yes, we need copies of these documents)
Be sure that contact information on those named is on the Contact Information section of this form.

DOCTOR'S ORDER
A person can only come into Luther Manor under a local doctor's care and order. If coming from home, A PHYSICAL AND HEALTH HISTORY form will be sent by us to the doctor a few days before admittance. If the resident hasn't seen the doctor in six months, get the records updated with a more recent appointment so that the doctor can make his referral. Obviously, this is not an issue when coming from a hospital. The doctor's order will be coming with the resident.

MEDICATIONS *(Don't fill this out if coming from the hospital; a meds list will be provided by them)*
Important note: *Do not purchase any medications before admission. Also, we cannot use unsealed medications from home. We* ***have*** *to get the medications* ***directly*** *from the pharmacy properly labeled and in unit dose packaging. Only Mercy Caremor and Hartigs do this in Dubuque. We also cannot order meds from a mail order source other than the VA*

Medication	Dosage	Frequency	Reason for the prescription
______________________	_________	___________	____________________
______________________	_________	___________	____________________
______________________	_________	___________	____________________
______________________	_________	___________	____________________
______________________	_________	___________	____________________
______________________	_________	___________	____________________

IMPORTANT: <u>Over the counter</u> medications <u>must</u> have a doctor's order and come from the pharmacy properly labeled! Do not bring them! Talk to the nurse about getting them for the resident from the doctor. We have to know what residents are taking!

SPECIAL CARES (Fill out special desires and daily routine on a separate sheet)
Hearing difficulties? _____________ Hearing aid(s) ___________
Seeing difficulties? _____________ Eyeglasses? _____________
Special Diet? _____________ If yes, what are the diet restrictions?______________________________
Able to feed self? __________ If not, what kind of assistance is needed? ________________________
Special Dinnerware ________________
Special Treatments for _____ Swelling _____ Bed Sores _____Catheter _____Incontinence
_____ Wandering _____ Insomnia Assistance with: _____ Bathing /Shower
_____Dressing _____ Teeth Helpful hints in approach: _____________________________
Use any of the following? _____ Oxygen _____Walker ______ Wheel Chair _____ Lift Chair
Mentally Alert _____ Slightly Forgetful _____ Confused _____ Very Confused _____

FINANCIAL INFORMATION
In order for us to plan for the future it is important that we be able to anticipate what you will be able to do financially. If on private pay and an average cost of around $170 per day, how long would the resident's finances be able to keep up such an effort?
___ One Year ___Two Years ___ Three years ____ More ___ Presently, or soon to be on Title 19

Nursing Home Insurance Company Policy? _____ Yes _____ No

If yes, name of company: ______________________________ Policy # _______________

CONTACT PERSONS

Please provide the following information on contact people. Include all those involved.
If additional space is required, please put them on a separate sheet.

Name ____________________________________ Spouse__________________
Phone (home)____________ (work)_____________ Cell Phone ______________
Address ________________________ City _____________ State ___ Zip _____
Relationship _______________

Name ____________________________________ Spouse__________________
Phone (home)____________ (work)__________ Cell Phone _________________
Address ________________________ City _____________ State ___ Zip _____
Relationship _______________

Name ____________________________________ Spouse__________________
Phone (home)____________ (work)__________ Cell Phone _________________
Address ________________________ City _____________ State ___ Zip _____
Relationship _______________

(Write additional contact information on the back)

This information has been prepared by:

Date

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AT ADMISSION TIME:

TB SKIN TESTING. If the resident has not had a recent TB skin test, **they must** have this just days before being admitted. The hospital can do this while the resident is there, or, if at home, you can arrange to have this done with your own doctor's office. This is a requirement set by the State of Iowa.

LABEL CLOTHING even if the family chooses to do the laundry. Bring the personal clothing to our laundry right away when you come. They have a special labeling machine. Start with a minimum of about a week's worth of clothes.

SMOKING is not allowed on the Luther Manor premises.

WHEN WAITING FOR ADMISSION: *TO REMAIN ACTIVELY ON THE WAITING LIST*

To be considered for admission, you must return this information to Luther Manor filled out as best you can. If we can't get you in right away, it is important that you keep your name in front of us by periodically making us aware of your continued interest. If you don't call, we may well assume that you have made other arrangements. We will do our best to be of assistance, especially in a crisis. Filling this out has been a great first step. Thank you.