

PROVIDENCE CARE CENTER ADMISSION INQUIRY FORM

Thank you for your interest in Providence Care Center. By completing and returning this form, information about the prospective resident will be reviewed by the Care Center's Admissions Committee. Please return form to Providence Care Center Attn. Admissions Director, 2025 Hayes Avenue, Sandusky, OH 44870

Prospective

Resident's Name Last _____ First _____ Middle _____ **Marital Status** _____

Home Address _____ **Phone** _____
Street

Birthdate _____ / _____ / _____
City State Zip Month Day

Responsible

Party's Name Last _____ First _____ Middle _____

Home Address _____ **Phone** _____
Street

City State Zip

Prospective Resident currently at:

How did you find out about Providence Care Center:

- | | | | |
|---|---------------------------------------|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Home | <input type="checkbox"/> Asst. Living | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Hospital | | <input type="checkbox"/> Presentation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Nursing Facility | | | |

Please list any nursing home(s) and date(s) Resident was admitted to within the past calendar year: _____

Prospective Resident's Current Condition (check all those which apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Alert | <input type="checkbox"/> Combative | <input type="checkbox"/> In chair/bed most of the time |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Feeds self | <input type="checkbox"/> Dresses self |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Needs assistance eating | <input type="checkbox"/> Needs assistance dressing |
| <input type="checkbox"/> Demanding | <input type="checkbox"/> Walks alone | <input type="checkbox"/> Blind |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Walks with assistance | <input type="checkbox"/> Deaf |
| <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Uses wheelchair or walker | <input type="checkbox"/> Incontinent |

Diagnosis: _____ **Physician:** _____

Current medications: _____

Additional medical/psychological problems: _____

Pay Status (Please check one): Private Pay _____ Medicare _____ Medicaid _____

Room Preference: Private _____ Semi-Private _____

Signature **Date**