

JAMES L. WEST CENTER

Resident Application

Residential Care _____
Respite Care _____

Date of Application _____

Applicant's Name _____

Address _____
Last _____ *First* _____ *Middle* _____

City _____ State _____ Zip _____

Phone _____ Birthdate _____ Age _____ Sex _____ Race _____

Social Security Number _____ Medicare Number _____

Private Insurance Number _____

Religious Affiliation _____

Clergyman/Rabbi _____ Telephone _____

Marital Status _____ Married _____ Single _____ Divorced _____ Widowed _____

If spouse is deceased, give date and cause of death _____

Wedding Anniversary Date _____

Durable Power of Attorney/Guardian Name _____

Address _____

City _____ State _____ Zip _____

Residence Phone _____ Work Phone _____

In emergency, notify _____

Address _____

City _____ State _____ Zip _____

Residence Phone _____ Work Phone _____

Have you applied to, or does the applicant presently reside in, another nursing home? _____

Date of admission _____ Where _____

Have you ever been denied residence in another nursing home? If so, state reason. _____

The following information is requested to assist the staff in developing an appropriate care plan to meet the individual, personal needs of the resident.

PERSONAL DATA

Applicant's trade or profession _____

Employer _____

Date of last employment _____ Spouse's occupation _____

If married before, spouse's name(s) _____

Number of natural or adopted children _____

NAME OF CHILD	ADDRESS	RES. PHONE	WORK PHONE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Applicant's hobbies or interests:

Present _____

Past _____

Clubs/Organizations _____

Family Member most dependent on _____

Relationship _____

Family member(s)/friend(s) involved (include supportive relationships) _____

HEALTH DATA

APPLICANT'S PHYSICIAN _____ Phone _____

Address _____

City _____ State _____ Zip _____

When did applicant last consult a physician or attend a clinic/hospital? _____

Will your physician supervise care at West Center? Yes _____ No _____

If no, please select a West Center Physician: Dr. Belfi _____ Dr. Knebl _____

APPLICANT'S DENTIST _____ Phone _____

Address _____

City _____ State _____ Zip _____

When did applicant last consult a dentist? _____

Will applicant transfer to a local dentist? _____

Height _____ Weight _____ Average Weight _____
Diet: Special _____ General _____

Appetite: Good Fair Poor

Food likes / dislikes _____

Alcohol use _____ Smoking habits _____

FUNCTIONAL AREAS:

Bathing: Self Needs assistance Bed Tub Shower Sink

Toileting: Bathroom Bed pan/urinal Incontinent Bladder
 Bowel Wears Incontinent Briefs

Up at night: _____

Dental Hygiene:
 Self Needs Assistance

Dressing:
 Self Needs Assistance

Hair Care:
 Self Needs Assistance

Nail Care:
 Self Needs Assistance

Feeding:
 Self Needs Assistance

Ambulation/Mobility:
 Unlimited Needs Assistance
 Bed Bound Chair
 Wheelchair Bound Walker/Cane

Hearing: Right Left
Hearing Aid: Right Left

Dentures:
 Upper Lower

Skin:
 Intact Pressure Ulcer Special Care

* Glasses: _____ Vision _____

* Please provide copy of the vision prescription upon admission.

Past Physical History (Include surgery and hospitalizations)

Present Condition/Diagnosis _____

Prosthesis _____

Death Policy: Heroic Measures Natural Death

Organ(s) Donation _____

Medications (include non-prescription drugs taken on a regular basis) _____

Pharmacy _____ Phone _____

Allergies (list with side effects) _____

EMOTIONAL AND MENTAL STATUS

Temperament and Personality _____

Changes in Behavior _____

When Changed _____

Mental Condition:

Mind Clear _____	Belligerent _____	Unkempt _____	Wandering _____
Fearful _____	Stealing from _____	Physically Abusive _____	Verbally Abusive _____
Demanding _____	Hoarding _____	Packing-Unpacking _____	Forgetful _____
			Attention Span _____

Orientation: Time _____ Place _____ Person _____

Communication Skills _____

OTHER DATA

Type of Room Preference: Private Semi Private (Only semi-private available on 4th floor.)

Will applicant want a private room when available? _____

Burial Pre-Payment Plan _____

Funeral Director _____ Phone _____

Address _____

City _____ State _____ Zip _____

A one month deposit is required to reserve a room, plus pre-payment of the first month's fees. Thereafter, you will be billed monthly.

Deposit _____
Enclosed: _____
Amount \$ _____ (including one months fees held in escrow) Check Money Order

The information I have provided in this application is current and correct to the best of my knowledge.

Signature _____ Date _____

Relationship to Applicant _____