POH
REGIONAL MEDICAL CENTER
A McLAREN HEALTH SERVICE

Lake Orion Nursing and Rehabilitation Centre

Admission Application
Smoke Free Environment

Date:__________________ Resident's Name:____
(Last) (First) (MI) (Maiden Name)
Address:____ City:________________________ State:______ Zip:__________
County:____________________________________ Date of Birth:________________ Age:_______ Sex: M_____ F_____
Marital Status: M___ W___ D___ S___ Phone:________________________ Soc. Sec#:____________________________
Is Resident a Veteran? Y____ N____ Branch:__________________________ VA#:______________________________
Is Spouse a Veteran? Y____ N____ Branch:__________________________ VA#:______________________________
Birthplace (state or country):_________________________ Country of Citizenship:_________________________________
Religion:____ Race:____
Funeral Home Preference:____
(Name) (Address) (Phone)

Insurance Information
Medicare #_________________ Medicaid#_________________ PDP#_____________ PCN____________ BIN___________
Private Insurance:____________________________ Contract #:______________________ Group #:_________________
Third Party insurance:____

In Case of Emergency:
Name:____________________________________ Relationship:____________________ Phone:(___)__________________
Address:____ Phone:(___)__________________
City:____ State:________________ Zip:_________________

Name:____________________________________ Relationship:____________________ Phone:(___)__________________
Address:____ Phone:(___)__________________
City:____ State:________________ Zip:_________________

Name:____________________________________ Relationship:____________________ Phone:(___)__________________
Address:____ Phone:(___)__________________
City:____ State:________________ Zip:_________________

Billing To Be Sent To:
Name:____________________________________ Relationship:____________________ Phone:(___)__________________
Address:____ Phone:(___)__________________
City:____ State:________________ Zip:_________________

Patient Currently Resides:____ Date: From:______________To:______________
Last Hospital Name:____ Date: From:______________To:______________
Has Patient Been in Another Skilled Nursing Facility in the Last 60 Days? Y_______ N_______ (If Yes answer below)
Name of Facility:____ Date: From:______________To:______________
Resident's Primary Physician Name:____ Phone#:_____________________
Address:____ City:______________________________ Zip:____________
Lake Orion Nursing and Rehabilitation Centre Physician Prefference:____
Allergies:____

Height:________ Weight:______ Patient Ambulates with: Self:_______ Wheelchair:_______ Walker:______

Current Diagnosis:____

Current Medications:____

____

____

Mental Status(Please Check all that apply) Alert:____ Comotose:_____ Cooperative:____

Confused:_____ Restless:____ Anxious:_____ Combative:___ History of Mental Illness:___

Any specific Behaviors?____

____

Please provide us with additional information important in the care for your loved one:________________

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History:

Lifetime Occupation:____

Level of Education Completed: Grade:_____ High School:___ Tech/Trade School___ Some College___
Bachelor's Degree:___ Graduate Degree:____

Primary Language:____

Residential History in the past 5 years: Own Home___ Lived Alone:___ Nursing Home:____ Group Home:____
Assisted Living:____ Mental Health Facility:____

Customary Routine (One year prior to admission)

Stays up late at night (E.G. after 9PM).	Yes___	No___
Naps Regularly during the day (At least one hour).	Yes___	No___
Goes out one or more days a week.	Yes___	No___
Stays Busy with hobbies, reading, or fixed daily routine.	Yes___	No___
Spends most of the time alone or watching TV.	Yes___	No___
Moves independently indoors (with appliance, if used).	Yes___	No___

Eating Patterns

Distinct food preference.	Yes___	No___
Eats between meals all or most days.	Yes___	No___
Use of alchoholic beverages(s) at least weekly.	Yes___	No___

Activities of daily living patterns

In bedclothes most of the day.	Yes___	No___
Waken to toilet all or most days.	Yes___	No___
Has irregular bowel movement pattern.	Yes___	No___
Prefers Showers to bathing.	Yes___	No___
Prefers PM bathing/showers.	Yes___	No___
Has smoked in the past.	Yes___	No___
Is presently a smoker.	Yes___	No___

Social

Daily contact with relatives/close friends. Yes___ No___

Usually attends church, temple, synagogue, ect. Yes___ No___

Finds strength in faith. Yes___ No___

Daily animal companion/presence. Yes___ No___

Involved in group activities. Yes___ No___

Medical

Does the applicant currently use oxygen? Yes____ No____ If yes, how often:____________________

Does the patient currently require dialysis? Yes___ No___

Is patient currently in a hospice program? Yes____ No____ If yes, how often:____________________

Does applicant have a tracheotomy? Yes___ No___

Legal Guardian? Yes___ No___ Name:____ Phone:__________________

Address:____ City__________________ State:______ Zip:_______________

Power of Attorney? Yes___ No___ Name____ Phone_________________

Address:____ City__________________ State:______ Zip:_______________

Power of Attorney Medical Provisions? Yes___ No___ Name_________________________ Phone_________________

Address:____ City__________________ State:______ Zip:_______________

*Please provide all legal documents, social security card, medicare card and other medical cards to Lake Orion Nursing and Rehabiltiation Centre upon admission.Copies will be made and the originals will be returned to you immediately.

Final Disclosure

AS STATED IN SECTION 7 OF THE RIGHTS AND RESPONSIBILITIES: "A patient is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations."

Source of income:

$__________ Social Security

$__________ Pension

$__________ Annuity

$__________ VA

$__________ Life Insurance

$__________ Savings/Checking

$__________ Certificate of Deposit

$__________ Mutual Funds

$__________ Rental Income

$__________ Other

Debts: Yes___ No___ Amount$_________________

Application Must be Signed and Dated

Signature of person completing application:____

Date:______________________________________

MICHIGAN LAW REGARDING NURSING HOME ADMISSION

ACCORDING TO STATE LAW, AS OF JANUARY 1, 1992 OLDER ADULTS MUST BE AFFORDED THE RIGHT TO SIGN THEIR OWN NURSING HOME ADMISSION PAPERS.

THEREFORE, PRIOR TO ALL ADMISSIONS, THE ADMISSION PAPERWORK IS TO BE SIGNED BY THE PERSPECTIVE RESIDENT, OR LEGAL REPRESENTATIVE.

LAKE ORION NURSING & REHAB CENTRE WILL BE HAPPY TO GIVE YOU A COMPLETE ADMISSION PACKET TO PRESENT TO THE PERSPECTIVE RESIDENT. IT CAN BE TAKEN TO THE HOSPITAL OR HOME FOR THE SIGNATURE. THESE DOCUMENTS, AGAIN ACCORDING TO THE STATE LAW, MUST BE WITNESSED BY A NON-FAMILY MEMBER.

ALL APPLICATIONS WILL BE KEPT ON FILE FOR SIX (6) MONTHS