FALLON MEDICAL COMPLEX

PO Box 820 ♦ Baker, Montana 59313-0820

LONG TERM CARE PRE-ADMISSION/ADMISSION INFORMATION SHEET

This Facility is owned and operated by Fallon Medical Complex, INC.

Fallon Medical Complex accepts residents of all backgrounds who are in need of 24 hour nursing care. The facility has a combination of 25 beds – inpatient, skilled Medicare and intermediate swing bed and nursing home beds.

Fallon Medical Complex is staffed with healthcare professionals, managers and staff who strive constantly to make the facility a place where the residents are treated with dignity and respect.

Room rates will be discussed with the prospective resident and his/her responsible party by the Interdisciplinary Team, which consists of nursing, social services, activities, dietary, and business office personnel.

Admission procedure is based on the following:

- The Facility must have a current Application for Admission completed by the perspective resident and/or the responsible party.
- Once the above information has been received, the application will be reviewed for admission by the Interdisciplinary Team. **Upon acceptance and prior to admission**, the perspective resident must be seen by a medical provider for a nursing home admission physical.
  When a bed becomes available for an approved resident, the resident/responsible party will be notified and admission arrangements will be made at that time. (All residents will be admitted at a pre-arranged time during regular business hours).
- **The Interdisciplinary Team requests that the potential resident/responsible party bring copies of any legal documents(which include Financial Durable Power of Attorney, Medical Durable Power of Attorney, Guardianship, Advance Directives, Living Wills, etc.). Also bring any LTC Insurance information, Medicare Card, Medicaid Card, Social Security Card. *PAYMENT IS EXPECTED THE DAY OF ADMISSION – PAYMENT AMOUNT WILL BE PRORATED FOR ANY PARTIAL MONTH AND THE FOLLOWING MONTH. ALL RESIDENTS/RESPONSIBLE PARTIES WILL BE REQUIRED TO SIGN A PROMISSORY NOTE UPON ADMISSION REGARDLESS OF PAY SOURCE. RESPONSIBILITIES OF THE POWER OF ATTORNEY WILL BE DISCUSSED AT THE ADMISSION CONFERENCE.***
  If you have any questions, please feel free to contact Jeanna Sullivan, BSW, Social Services Director at 406-778-5403, Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. Please feel free to fax this document to 406-778-5326.

PLEASE NOTE THAT COMPLETION OF THE PRE-ADMISSION FORM DOES NOT GUARANTEE PLACEMENT AT THIS FACILITY.

Current room rates – please contact Social Services at 406-778-5403

When accepted to Fallon Medical Complex Nursing Home please bring the following to your clinic appointment before admission:

1. Please bring all medications, *in their original bottles*, that you are currently taking. This includes herbal supplements, vitamins, eye drops and any over the counter medication. This is so you can review these with your provider to ensure you or your loved one receives the correct medications here at FMC.

2. Please be sure to write a list of all questions or concerns you have about long term placement, pain, skin issues, etc. so the provider can answer or prescribe something to make the transition easier for you and your loved one.

3. If your loved one is having problem chewing or swallowing be sure to let your provider know so he/she can order the correct diet.

4. If there any special treatments (i.e. corn pads) or care that you are providing at home that you would like to see continued here at Fallon Medical Complex please be sure to let your provider know.

5. Thank you for your help and cooperation in making sure we provide the best care for your loved one!

PLEASE COMPLETE ALL SECTIONS

Applicant/Resident Information:				
Name:	Date of Birth:		Age:	Sex:
Address:	City:	State:	Zip:	Phone: ( )
Religion:	**Marital Status:** S M W D		**Birth Place:**	
Social Security Number:	Medicare Number:		Medicaid Number:	
Health Insurance:				
Maiden name:	**Mother's maiden name:**		Military: oYes oNo Branch:	
Attending Provider in Baker: o **Carrie Haar, FNP** o**Kate Ernest, PA** o**Carol Hough, FNP** **Room Preference: _____Private**			**Payer Source: Must be completed:** o **Medicaid** o **LTC Insurance** o **Private Pay** **PAYMENT EXPECTED DAY OF ADMIT – WILL BE PRORATED FOR PARTIAL MONTH AND FIRST FULL MONTH**	

Hospitalization:		
Have you been hospitalized in the last 12 months? o Yes o No If **Yes,** please complete the following information:		
Acute Hospital Name: (Most Recent)	Admit Date:	Discharge Date:
Skilled Nursing Facility Name: (Most Recent)	Admit Date:	Discharge Date:
Applicant/Resident is currently residing at:		Admit Date:

In Case of Emergency, Notify:			
Name:		Relationship:	
Home Phone: ( )	Business Phone: ( )		
Address:	City:	State:	Zip:
Name:		Relationship:	
Home Phone: ( )	Business Phone: ( )		
Address:	City:	State:	Zip:

Responsible Party:			
Name:		Relationship:	
Home Phone: ( )	Business Phone: ( )		
Address:	City:	State:	Zip:
Send Statement/Bill To: (Name, Address, Phone)			

Legal Documentation			
Do you have the following documents? (Beneficial for everyone concerned, please bring copy to admission conference)			
o Durable Power of Attorney	o Durable Medical Power of Attorney	o Living Will	o Guardianship
o Five Wishes	o POLST	o Organ Donor	

FALLON MEDICAL COMPLEX – LONG TERM CARE
APPLICANT/RESIDENT SOCIAL EVALUATION

Applicant/Resident Information:	
Applicant/Resident Likes To Be Called (Nickname)	
Current Living Arrangements: o House o Apartment o Other:	
Do You Live Alone? o Yes o No Explain:	
Previous Occupation:	**Education:**

Family Members:	
Spouse Name: o Living o Deceased, date:	
Children: (If more, list on back of form)	
Name:	Phone: ( )
Name:	Phone: ( )
Name:	Phone: ( )
Name:	Phone: ( )
Interested Others:	
Name:	Phone: ( )
Name:	Phone: ( )
Who will visit?	How often?

Special Interests:
Hobbies:
Club Memberships:
Recreational Activities:
Other Interests:

Psychosocial:
Has individual been informed of possible admission to the nursing home? o Yes o No
How do you feel about your present situation?
How does your family feel about your present situation?
Do you have any financial concerns?
Have you had any recent losses? o No o Yes Please Explain:
Handicaps? o No o Yes If yes, how does this make you feel?

Completedby:_____Relationship_____Date:_____

APPLICANT/RESIDENT PHYSICAL HEALTH HISTORY

Current Physical Health Problems:			
o Alzheimer's	o Diabetes	o Hypertension	o Pain
o Dementia	o Heart Disease	o Obesity	o Contractures
o Hearing Impaired	o Limited Vision	o Seizure Disorder	o Paralysis
o Bowel Incontinence	o Respiratory	o Cancer	o Speech Impaired
o Parkinson's	o Blind	o Fracture	o CVA/Stroke
o Arthritis	o Feeding Tube	o Urine Incontinence	o Gastrointestinal Disorder
o Decubitus Ulcer	o Catheter Use	o Infections (UTI, Respiratory, etc.)	
o Hallucinations	o Smoker	o Alcohol Consumption	o Clostridium Difficile
o VRE	o MRSA	o Pressure Sore/Wounds	o Pacemaker Placement
o	o	o	o

Which of the following best describes the applicant's / resident's ability to walk:	
o Fully independent	o Uses wheelchair independently
o Unsteady	o Uses wheelchair with assistance
o Uses cane or walker independently	o Uses gait belt
o Uses cane or walker with assistance	o Total assistance with transfers
Falls History: o Yes o No Most Recent Fall Date:	How many falls in last month?
Comments:	

Which of the following best describes the applicant's / resident's behavioral status:		
o Knows people	o Able to verbalize feelings	o Crying
o Knows where they are	o Confused	o Anxious
o Knows day of week, season etc.	o Forgetful	o Nervous
o Able to make eye contact	o Noisy	o History of psychiatric treatment
o Opens eyes but does not respond	o Aggression o Verbal o Physical	o Yells out
o Unresponsive to stimuli	o Angry	o Wanders
o Sexually inappropriate behavior	o Agitated	o Depression
Comments:		

Socialization/Activity Interests:		
o Prefers to be Alone	o Enjoys Being Around Others	o Occasionally Enjoys Being Around Others
Usual Bedtime:	Naps o Yes o No Time of Day:	
Bath: o Tub o Shower o a.m. o p.m.		

Mortuary (required):			
Have pre-arrangements been made? o Yes o No			
Mortuary Name:		Phone: ( )	
Address:	City:	State:	Zip:

APPLICANT/RESIDENT PHYSICAL HEALTH HISTORY

Personal Care Activities:					
	Fully Independent	Needs Supervision	Needs Some Physical Assist	Needs Much Physical Assist	Needs Total Care
Bathing	o	o	o	o	o
Eating	o	o	o	o	o
Dressing	o	o	o	o	o
Toilet Use	o	o	o	o	o
Bed Mobility	o	o	o	o	o
Personal Hygiene	o	o	o	o	o

Nutritional Status:				
Special Diet:				
Adaptive Equipment:	o"Raised Lip" Dishes	o Weighted Utensils	o Other:	o

Oral Care:				
o Own Teeth	o Full Dentures	o Partial Dentures	o Upper Dentures	o Lower Dentures
o Missing Teeth	o Dental Cavities	Last Dental Exam Date:		
Name of Dentist:		Address/Phone:		

Vision:				
o Normal Vision	o Wears Glasses	o Limited (Large Print)	o Legally Blind	Last Exam:
Name of Eye Doctor:		Address/Phone:		

Hearing:
o Normal Hearing o Hearing Loss (o Right Ear o Left Ear)
o Hearing Aide (o Right Ear o Left Ear)

Pharmacy currently using :	**Will you continue to use this pharmacy o YES oNO**
Name of Pharmacist	Address/Phone Number:

Currently Using Oxygen? oNo oYes, Company using: _____

_____

Current weight: _____ **Current height: _____**

Does the potential resident have any special needs?:

□ Colostomy □ Urostomy □ Porta Cath □ Groshong □ Trach □ Illyostomy □ Feeding tube

FALLON MEDICAL COMPLEX - LONG TERM CARE

APPLICANT/RESIDENT PHYSICAL HEALTH HISTORY

List all allergies:

CURRENT MEDICATION LIST

Medication/Drug	Amount/Dosage (mg, etc.)	Is it taken by mouth or Injection	What time of day or night?

Please write a short summary that explains what brought you to the decision of nursing home placement, and what an example of a normal day is now, and any special things you or your loved ones like.

Current/Past Medical History:

Surgical History:

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Management Evaluation:	
FOR OFFICE USE ONLY*	
Evaluated by:	Date: