Patient Information

(attach face sheet)

Name:			Age:	**********For SNF Use Only**********	
Room #:	Height:	Weight:	Smoker: YES NO	Admission Time:	Admission Date:
Family spokesperson/Relationship:				Room #:	MR:
Main Phone:	Work:	Cell:		**Hospital Admit Date:** (Inpatient; not observation bed)	
Alternate Contact:				SNF Date:	ICF Date:
Main Phone:	Work:	Cell:		Skilled Service:	
Alternate Contact:				Diagnosis:	
Main Phone:	Work:	Cell:			
Living Will:	DPOA-HC:	Guardianship/Surrogate:			

Insurance Coverage

(circle & attach face sheet)

Medicare Kaiser Sr 65C+ HMSA Medicaid Other:_____

Discharge Planning

☐Lived alone	☐Lived with family/spouse	☐Assisted Living	☐Senior Housing
☐Home Services Pre Admission	Type:		
	Frequency:		
Disposition:	☐LTC	☐Other_____	
	☐Home (Specify functional level required, i.e. 13 steps, car transfers)		

RecentSurgery

Type/Surgeon:

Date | Weight bearing restrictions

Code Status:

Attending MD:

PCP: | Will follow? Yes No

Functional Status

	Pre Admission	Current Level	Scale
Cognition	☐Oriented ☐Forgetful ☐Confused ☐Agitated ☐Lethargic	☐Oriented ☐Forgetful ☐Confused ☐Agitated ☐Lethargic	
Continent	0 1 2 3 4 5	0 1 2 3 4 5 ☐Foley	0 Independent
Eating Diet_____	0 1 2 3 4 5 ☐ NG/PEG	0 1 2 3 4 5 ☐ NG/PEG	2 Minimum Assistance (≤ 25% assist)
Bed Mobility	0 1 2 3 4 5	0 1 2 3 4 5	3 Moderate Assistance (≤ 50% assist)
Transfer	0 1 2 3 4 5	0 1 2 3 4 5	4 Maximum Assistance (≤ 75% assist)
Ambulation	0 1 2 3 4 5	0 1 2 3 4 5	5 Dependent (100% assist)
Assistive Device (specify)	0 1 2 3 4 5	0 1 2 3 4 5	

Special Problems/Treatments

CXR Date: ☐Result:

PASARR:

Decubitus/Wound/Culture/Amputations:

O2/Nebs/Trach care:

☐Midline ☐PICC line ☐Central line

Hemodialysis: Days/Chair Time

Transportation Arrangement?

Behavior: ☐Combative ☐Abusive ☐Yells ☐Wanders

Restraint: Reason:

Comments

Medications

(may list or Attach MAR)

Allergies:

Completed by: Date: