GARDEN COURT CHATEAU

2495 SW 8th Street, Grand Rapids, MN 55744

Phone: (218) 999-5999 Office: (218) 999-5998 Fax:(218) 999-5996

RESIDENT APPLICATION: **Date:**___________________

Name:____
Last First (Legal) Middle Preferred Name

____
Address apt. #

____
City State Zip

Phone #: ( ) ____________________ County___________________________________

Present Living Arrangements:

_____Alone in house/apartment

_____With__________________________(relationship)_______________________in house/apartment

_____Assisted Living (name)____

_____Nursing Home____
Name City State Admit Date

_____Other____(Specify)

Date of Birth:_________________ Birth Place:_______________________________________

Marital Status: Married_____ Divorced_____ Never Married_____ Widowed_____

Spouses Name: _____________Address:______________________________ Phone #______________

Names, addresses and phone # for children and/or contact person(s) : Number of children_____

____

____

____

____

____

Application Status
Active______ Date______
Inactive______ Date______

Do you have a pet: Yes_____ No_____ If yes, what type____________

Level of education completed: _______________
Former
Occupation(s):____

Religious Preference:___________________________________Pastor:_____________________________

Do you want your pastor/church notified? Yes_____ No_____ Phone # (   ) ____________________

Address:____

Physician:______________________________ ____
Name Clinic

____
Address City State Zip

Phone #: (   ) _____________________ Fax: (   ) _____________________

Other Medical Specialists:

____
Name Specialty

Clinic: ______________________________ Phone #: (   ) _____________________

Address: ____ Fax: (   ) _____________________

Preferred Hospital: ________________________________City:_____________________________

Advanced Directives: *Check all that apply and please attach copies.*

_______Do Not Resuscitate _______Do Not Intubate

_______Health Care Directive _______Mental Health Directive

____Healthcare Power of Attorney (____)
Name

____Financial Power of Attorney (____)
Name

Medical Insurance and Provider: ____

Phone #: (   ) _____________________________Fax: (   ) _____________________________

Claim #:__________________________ Group #________________________Effective Date__________

____
Address City State Zip
Please attach a copy of your Medicare, Social Security, and Medical Insurance Cards

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Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Medical Assistance #: ____________________
Effective Date: _________________________

Medicare #: __________________________________ VA Claim #: _________________________
Part A-Hospital Effective Date:____________ Dates of Service: _________to___________
Part B-Medical Effective Date: ____________

Railroad Retirement #:________________________________

Are you or your spouse a War Time Vet? Yes______ No______

If yes, you may be eligible for VA benefits.
Call Itasca County Veterans Service Office
(218-327-2858)

Do you have State/County Assistance? Yes_____ No_____ Name of Case Worker_________________

Prior Authorization # _________________

Elderly Waiver? Yes_____ No_____ Itasca County Elderly Waiver Program #_______________

Cdai? Yes_____ No_____

Private Funds? Yes_____ No_____

If applying for Medical Assistance: Date applied:______________________

Financial Worker:_____________________ Phone #: ( ) ______________ County___________

Pharmacy:

Name: _____________________Phone #: ( ) ______________Fax: ( ) _______________

Will this pharmacy deliver to Garden Court Chateau? ____yes ____no If no, who will pick up

prescriptions? ____

Mail Order Company: ________________________________
Phone #: ( ) ______________Fax: ( ) _______________

Mortuary: Regulations require that we have the name of the Mortuary to be called in case of death.

Name: ___________________Address: ____

City:____________________State: __________________ Phone:_____________________________

Pre-paid funeral arrangements? ____yes ____no

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Business mail to be sent to:

Name:_______________________________________ Phone #: (   ) _______________

Address:_____________________________________ City:___________________________

State:____ Zip: __________________________

(Please notify Post Office of Resident's change of address)

Medical Conditions: ____

____

Surgical History:____

____

History of:

Alcohol abuse: Yes_____ No_____ Unknown_____

Drug abuse: Yes_____ No_____ Unknown_____ If yes, type of drug_____

Smoking: Yes_____ No_____ Currently smokes: Yes_____ No_____

If yes, how much?_____________________ If quit-how long ago?_____________

Psychiatric Illness: Yes_____ No_____ If known, what type?____________________________________

____

Medications:

Name of Drug	Dosage	How often taken	Time normally taken
___________________	__________	______________	_________________
___________________	__________	______________	_________________
___________________	__________	______________	_________________
___________________	__________	______________	_________________
___________________	__________	______________	_________________
___________________	__________	______________	_________________
___________________	__________	______________	_________________
___________________	__________	______________	_________________

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Drug Allergies:	**Type of Reaction:**
______________________	________________________
______________________	________________________
______________________	________________________
______________________	________________________

Ambulation: Walks unassisted_____ Needs assist_____ Cane_____ Walker_____ Wheelchair_______

History of Falls: When____________ How often_____________ Related to__________________

Mental Condition: Alert/oriented_____ Alert/oriented but forgetful_____ Disoriented_____

Speech: Preferred language if other than English__________________

Bowel Elimination: Continent_____ Incontinent_____ (uses pads_____)Frequency_____
Constipation difficulties_____Uses Laxatives_____Enema_____

Urinary: Continent_____ Incontinent_____Frequency_____ Dribbling_____(uses pads_____)

Hearing: Wears a hearing aide: ____yes ____no Which ear (L)____ (R)____

Hearing Aide Model____________________

Vision: Wears Glasses____ Contact lenses____ Cataracts____ Glaucoma____

Description of Glasses__________________ Marked for identification? ____yes ____no

Skin: Open areas ____yes ____no If yes, where____

Describe any skin conditions____

Dentures: Upper____ Lower____ Partial____ Marked for identification ____yes ____no

Orthotics: ____yes ____no Type____

Signature of Resident, Family Member/Significant Other Completing Form:

____

Relationship____

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55744 CURRENT ABILITIES

Check areas that accurately describe you/your relative at this time. Comment if needed.	Occurs frequently (within a week)	Occurs occasionally	Rarely or Never occurs
ORIENTATION			
1. Unaware of day or date			
2. Doesn't know home is where they live			
3. Wandering or getting lost			
4. Trouble remembering events			
COMMUNICATION			
1. Unable to write			
2. Unable to read			
3. Unable to communicate needs clearly			
4. Experiences word finding difficulty			
5. Unable to communicate basic needs			
6. Unable to understand simple directions			
7. Unable to understand any directions at this time			
AMBULATION			
1. Loss of balance or falling when walking			
2. Unusual gait (shuffling, leaning, fast pacing)			
3. Has difficulty sitting is a chair			
4. Bumps into things (walls, furniture)			

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ACTIVITIES OF DAILY LIVING

Codes: **1**. Independent **2.** Needs Some Assist **3.** Totally Dependent
Check appropriate number

	1	2	3		1	2	3
1. Ability To Feed Self Helpful ways to assist______________________ _________________________ _________________________ _________________________ Adaptive devices needed: ☐ No ☐ Yes If yes, devices used____________________ _________________________				**2. Ability to Toilet Self** Helpful ways to assist_________________________ ____________________________ ____________________________ Is continent of bowels: ☐ Always ☐ Sometimes ☐ Never Concerns (constipation, loose stools)______________________ ____________________________ ____________________________ Is continent of bladder: ☐ Always ☐ Sometimes ☐ Never Concerns____________________ ____________________________ ____________________________			
3. Ability To Dress Self Helpful ways to assist_________ __________________________ __________________________ ___________________________ Need for Special Clothing ☐ No ☐ Yes If yes, explain____________________ ___________________________ ___________________________	**1**	**2**	**3**	**4. Ability To Do Dental Care** Helpful ways to assist_________________________ ____ ____ ____	**1**	**2**	**3**

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5. Ability to Bathe Self Prefers: ☐ Bath ☐ Shower Times of day Frequency (per week) Helpful ways to assist__________ ______________________________ ______________________________ ______________________________	1	2	3

6. Ability To Wash Own Hair Washes: ☐ In shower ☐ In Sink ☐ At beauty shop ☐ Other Helpful ways to assist ______________________________ ______________________________ ______________________________	1	2	3

7. Ability To Shave Self ☐ Razor ☐ Electric Razor Helpful ways to assist ________________________________ ________________________________ ________________________________	1	2	3

8. Ability To Use Make-Up Still likes to use: ☐ No ☐ Yes Helpful ways to assist:_____________ ______________________________________ ______________________________________	1	2	3

SLEEP PATTERNS

1. Sleeps through the night: ☐ No ☐ Yes
2. Frequently awakes at night: ☐ No ☐ Yes
3. Sleeps during the day: ☐ No ☐ Yes
   Nap Times:___________________________
4. Usual time to arise ___________________
5. Usual time to retire ___________________
6. Sleep related concerns _________________
____
____
7. Helpful ways to assist__________________
____
____
____

DIETARY

Preferred Fluids:
Breakfast____________________
Lunch_______________________
Dinner______________________
Between Meals_______________
____

Favorite Foods:
Breakfast____________________
Lunch_______________________
Dinner______________________
Between Meals_______________

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Food Dislikes/Intolerances

____

____

____

Food Allergies_____________________

____

Foods that help relieve:

Constipation_______________________

Loose Stools_______________________

Dietary	Yes	No	Sometimes	Time of Day
1. Do you: a. Eat breakfast? **b.** Eat lunch? **c.** Eat dinner? **d.** Snack?				
2. Are you able to: a. Feed yourself? b. Use regular utensils				
3. Have you had a: a. Significant weight loss in the last 3 months? If yes, how much?______ b. Significant weight gain in the last 3 months? If yes, how much?______				

PAIN ASSESSMENT

Do you experience routine or occasional discomfort due to a physical condition (headaches, joint pain)?

____

____

What is your most usual way of acknowledging this pain?

____

What usually relieves your pain/discomforts?

____

ACTIVITY

What type of leisure activities have you enjoyed in the past?

____

____

What type of leisure activities do you still enjoy doing?

____

____

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MOODS AND BEHAVIOR

Codes: **1**. Behavior hasn't occurred in the past week **2.** Behavior occurs less than daily **3.** Behavior occurs daily or more frequently

Check appropriate code number	1	2	3
1. Wandering			
2. Continuous Pacing			
3. Repetitive behaviors (words, actions)			
4. Withdrawn/depressed (long periods of inactive time)			
5. Appears anxious, worried			
6. Crying, tearful			
7. Sleep disturbances (insomnia, or frequent napping			
8. Mood swings (sudden changes in mood)			
9. Overeating			
10. Under eating			
11. Clinging(to caregiver, can't leave site)			
12. Verbally abusive (curses, screams, threatens)			
13. Physically abusive (strikes out at caregiver)			
14. Rummaging or hoarding (goes through things or hides things)			
15. Inappropriate toileting habits			
16. Inappropriate sexual behavior			
17. Sun downing behavior (difficult behaviors or increased confusion occurs in late afternoon)			
18. Hallucinations (hears or sees things that are not there)			
19. Delusions (tells stories that are not fact based)			
20. Suspiciousness			
21. Resistant to care			
22. Repetitive verbalizations or behaviors			
23. Catastrophic reactions (overreacts to stressful situations)			

When you are upset, what is the best way to comfort you? ☐ Humor ☐ Affection ☐ Food (snack)
☐ Going for a walk ☐ Leaving alone ☐ Other ____

Are there situations that upset you? ☐ Car rides ☐ Being alone ☐ Unfamiliar surroundings ☐ Demands (personal care)
☐ Being touched ☐ Other ____

BEHAVIOR RELATED CONCERNS/COMMENTS

____

____

We request you secure all valuables for safekeeping prior to admission. Thank You!

Signature of Resident, Family Member/Significant Other Completing Form:

____

Relationship____

Signature of Interviewer____