



Application for Potential Admission

Please fill out completely to the best of your ability.

Name of Applicant: _____ DOB: _____

Marital Status: _____ Social Security Number: _____ - _____ - _____

Insurance: Please give policy numbers.

Medicare: _____ Blue Chip: _____

Other: _____

Semi-private rate: \$260.00 per day. Private pay; estimated length of private pay: _____

Long Term Care Insurance: yes / no Policy name and number: _____

Medicaid: _____ **NEEDED** **STARTED** **COMPLETED**

Family/Responsible Party/POA: _____ Phone number: _____

Address of Responsible Party/POA:

Length of stay expected: Rehab only Short-Term Long-Term

Primary Care Physician in community: _____ Phone/Fax #: _____

Allergies: _____

Circle if appropriate:

Diabetes / CHF / Alzheimer's/dementia / Parkinson's / COPD / Hypertension / CVA/stroke / MS /
Depression/anxiety / Frequent UTI / pneumonia / Crohn's disease / Cancer _____

other: _____

Current Medications:

Present Location: _____

Prior Admission to Hospital/Nursing home in last 30 days? Yes / No

Name of facility: _____

Level of assistance needed with daily activities:

Is he/she able to walk? Yes / No Device use: _____

Mental Status: alert/oriented / confused / mildly intact / moderate impairment / severely impaired

Are there any behavioral issues (wandering, ect.)

Height: _____ Weight: _____ Loss or gain in last 6 months: _____

Continent of bladder: yes / no Continent of bowels: yes / no Use of briefs or pull ups? _____

Eyesight: _____ Hearing: _____

Speech/Language: _____ Appetite: poor fair good varies Personality: _____

Any current infections? _____

Any skin issues? _____

Any additional information that you feel may be helpful:

You will be receiving a return call at the number listed below after this has been reviewed.

Please email back to either of the following emails:

evelyn.callaghan@alpinenursinghome.com

jillian.degraide@alpinenursinghome.com

pat.keefe@alpinenursinghome.com

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