ATTENTION:

PLEASE INCLUDE COPIES OF THE FOLLOWING THAT APPLY, PLEASE COPY “FRONT” AND “BACK” OF CARDS:

1. SOCIAL SECURITY CARD
2. MEDICARE CARD
3. MEDICAID CARD
4. GROUP & INDIVIDUAL INSURANCE CARDS
5. MEDICARE SUPPLEMENT INSURANCE CARDS
6. VETERANS ADMINISTRATION “VA” BENEFITS ID

LEGAL DOCUMENTS:

1. LIVING WILL
2. POWER OF ATTORNEYS
3. GUARDIANSHIP

IN ORDER TO ACCESS WHETHER THIS FACILITY CAN MEET THE NEEDS OF THE APPLICANT, WE WILL REQUIRE THE FOLLOWING MEDICAL INFORMATION TO BE FAXED FROM THE APPLICANT’S PHYSICIAN WHEN A SPACE COMES AVAILABLE:

1. HISTORY AND PHYSICAL (WITHIN THE LAST 3 MONTHS)
2. LIST OF CURRENT MEDICATIONS
3. LAB WORK: CBC, URINALYSIS, RPR, CMP, EKG, CHEST X-RAY (WITHIN THE LAST 3 MONTHS)

*** WE MUST HAVE THESE BEFORE APPLICANT CAN BE ADMITTED!**

CHATUGE REGIONAL NURSING HOME
P.O. BOX 509
HIAWASSEE, GA 30546
706-896-2231

NEW RESIDENT INFORMATION PACKET
(Please print legible)

Resident's Full Name: ____ Date: __________________

Name Resident likes to be called: ____

Resident's Address and Phone Number: ____

____

____

Current Physician's Name, Address and Phone Number:

____

____

____

Diagnoses: ____

Admitted to Nursing Home from: ( ) Home ( ) Hospital ( ) Other Nursing Facility

If other nursing facility please list name, address, and phone number:

____

____

____

Admission diagnosis and date of onset: ____

Payor source: ( ) Private Pay ( ) Medicare ( ) Medicaid Pending

Responsible Party: ____ Relationship: ___________

Address: ____

Contact Numbers:

Home: ( ) _______________ Cell: ( ) _______________ Work: ( ) _____________________

Resident's Name: ______________________________________

Alternate Responsible Party: ____________________________________ Relationship: _____________

Address: ____

Contact Numbers:

Home: ( ) _______________ Cell: ( ) _______________ Work: ( ) ____________________

BACKGROUND INFORMATION/ HISTORY

Date of Birth: _______________ Age: ________ Social Security Number: _______________________

Place of Birth: ________________________ County: _____________________ State: ______________

Father's Name: ________________________ Mother's Name: _________________________________

Education Information: ____________________________________Can Resident Read?____________

Highest Level of Education: ____

Names of Sibling Living: ____

Names of Sibling Deceased: ____

Primary Language: English _______________ Other: ____

Marital Status: ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Single

Marriage #1, Name of Spouse: _______________________________________ Years Married: ______

Marriage #2, Name of Spouse: _______________________________________ Years Married: ______

Children Living: ____

Children Deceased: ____

Job(s) Held: ____

Military Service: ( ) Yes ( ) No **If Yes**, Branch _______________________When: _______________

Living arrangement prior to admission: ____

Lived Alone: ( ) Yes ( ) No

Feelings about nursing home placement: ____

Interested in voting: ( ) Yes ( ) No **If Yes**, Absentee ( ) Yes ( ) No, Go To Polls ( ) Yes ( ) No

Resident's Name: ____

Religion: __________________________Church Affiliation: ( ) Yes ( ) No Phone #: (   ) ____________

Location of Church: ____________________________Pastor's Name: ______________________________

Describe Resident's level of involvement with the Church: ____

____

Does Resident draw strength from faith? ( ) Yes ( ) No

Draw strength from faith during difficult times/ tragedies /serious health problems? ( ) Yes ( ) No

Life Style and Social Interest: ____

____

Any Comments: ____

____

____

____

EATING

Food Likes: ____

Food Dislikes: ____

Describe Appetite: ( ) Poor ( ) Normal ( ) Excessive

Does Resident need:

Chopped Meats ( ) Yes ( ) No, Soft Foods ( ) Yes ( ) No, Pureed Foods ( ) Yes ( ) No

Does resident need his/her beverages thickened? ( ) Yes ( ) No

What does resident drink for breakfast? ____

Does resident drink juice? ( ) Yes ( ) No

What does resident drink for lunch? ____

Does resident drink tea? ( ) Yes ( ) No Sweetened ( ) Yes ( ) No Unsweetened ( ) Yes ( ) No

What does resident drink for supper? ____

Food Allergies: __________________________ Height ______________ Usual Weight ______________

Resident's Name: ______________________________________

BEHAVIORS

Describe behavior when happy: ____

Describe behavior when sad: ____

Describe behavior when angry: ____

Has resident become violent toward family? ( ) Yes ( ) No

If yes, please describe behavior: ____

Does resident wander outside the home? ( ) Yes ( ) No

If yes, is behavior specific to certain time of day? _______________________________

Is resident easily redirected back into home? _____________________________________

Is resident cooperative when being assisted with daily care? ( ) Yes ( ) No

COMMUNICATION AND COGNITIVE PATTERNS

MAKING SELF UNDERSTOOD

________ Understood
________ Usually Understood
________ Sometimes Understood
________ Rarely/ Never Understood

ABILITY TO UNDERSTAND OTHERS

________ Understands
________ Usually Understands
________ Sometimes Understands
________ Rarely/ Never Understands

DECISION MAKING ABILITY

________ Independent
________Assist In New Situation
________Moderately Impaired
________Severely Impaired

ORIENTED TO

________ Person
________ Place
________Time

SHORT-TERM MEMORY

________ Good
________Adequate
________ Poor ________ Forgetful

LONG-TERM MEMORY

________ Good
________ Adequate
________ Poor

ATTITUDE

________ Alert
________Oriented
________Well Adjusted
________ Apathetic
________ Dwells on illness/other problems

________ Enthusiastic
________ Cooperative
________ Confused
________ Moody

________ Willing to try
________ Cheerful
________ Depressed
________Uncooperative
________ Withdrawn

Attitude towards life: ________Interested ________ Disinterested

Resident's Name: ______________________________

MENTAL HEALTH

History of, or current depression: ( ) Yes ( ) No

History of depression medication: ( ) Yes ( ) No

If yes, name of medication(s): ______________________________

History of self-injury: ( ) Yes ( ) No **If yes**, please explain: ______________________________

____

SPECIALITY PHYSICIANS

Name of Eye Doctor: ______________________________

Address: ______________________________ Phone Number: ______________

______________________________ Fax Number: ______________

Name of Cardiologist: ______________________________

Address: ______________________________ Phone Number: ______________

______________________________ Fax Number: ______________

Name of Podiatrist: ______________________________

Address: ______________________________ Phone Number: ______________

______________________________ Fax Number: ______________

Name of Dentist: ______________________________

Address: ______________________________ Phone Number: ______________

______________________________ Fax Number: ______________

Name of Neurologist: ______________________________

Address: ______________________________ Phone Number: ______________

______________________________ Fax Number: ______________

Other Physician Name and type of specialist: ______________________________

Address: ______________________________ Phone Number: ______________

______________________________ Fax Number: ______________

Resident's Name: ______________________________________

CARE PLAN INFORMATION

These questions pertain to resident's lifestyle before coming to the nursing home.

In the past 5 years has resident been admitted to an assisted living facility or nursing home?

( ) Yes ( ) No If yes, Assisted Living ( ) Yes ( ) No Nursing Home ( ) Yes ( ) No

Did resident have home health services before entering this facility? ( ) Yes ( ) No

If yes, name of home health service: ____

Any falls in the last 30 days? ( ) Yes ( ) No Last 180 Days: ( ) Yes ( ) No

In the last 90 days, number of times admitted to a hospital: _______, Emergency Room visits ______

Does resident have a diagnosis of mental retardation or a developmental disability? ( ) Yes ( ) No

Does resident go on trips outside the home one or more days a week? ( ) Yes ( ) No

Does resident stay busy with hobbies reading or fixed activities daily? ( ) Yes ( ) No

Does resident spend most time alone or watching television? ( ) Yes ( ) No

Does resident move independently indoors? ( ) Yes ( ) No

Does resident have distinct food preferences (ex. Vegetarian, meat, potatoes, sweets, etc.)?

( ) Yes ( ) No **If yes**, explain: ____

Does resident eat between meals all or most days? ( ) Yes ( ) No

Does resident stay in bed clothes much of the day? ( ) Yes ( ) No

Does resident waken to toilet at night? ( ) Yes ( ) No How often? ________

Does resident have an irregular bowel movement patterns? ( ) Yes ( ) No

Is resident continent of bowel and bladder? ( ) Yes ( ) No

Does resident prefer showers ______ **OR** baths _____? (Check one)

Does resident prefer to bathe in the morning _______ **OR** in the evening _______? (Check one)

Does resident have daily contact with relatives or close friends? ( ) Yes ( ) No

Is resident involved in any group activities? ( ) Yes ( ) No

Does resident have any decubiti? ( ) Yes ( ) No

Resident's Name: ___________________________________

Does resident have glasses? ( ) Yes ( ) No

Does resident need large print? ( ) Yes ( ) No

Does resident have history of cataract(s), with or without removal? ( ) Yes ( ) No

If yes, when: ____

Does resident have dentures? ( ) Yes ( ) No

_____ Upper ____ Lower ____ Partial

Does resident have hearing aid(s)? ( ) Yes ( ) No

____ Left ____ Right

Does resident have any impairment?

____ Sight ( ) Severe ( ) Moderate ( ) Mild ( ) None

____ Hearing ( ) Severe ( ) Moderate ( ) Mild ( ) None

____ Speech ( ) Severe ( ) Moderate ( ) Mild ( ) None

____ Ltd. Motion ( ) Severe ( ) Moderate ( ) Mild ( ) None

____ Paralysis ( ) Severe ( ) Moderate ( ) Mild ( ) None

How much help does the resident need with the following:

Eating ( ) Dependent ( ) Needs Assistants ( ) Independent
Wheel Chair ( ) Dependent ( ) Needs Assistants ( ) Independent
Transfers ( ) Dependent ( ) Needs Assistants ( ) Independent
Bathing ( ) Dependent ( ) Needs Assistants ( ) Independent
Ambulation ( ) Dependent ( ) Needs Assistants ( ) Independent
Dressing ( ) Dependent ( ) Needs Assistants ( ) Independent

Does resident have a pace maker? ( ) Yes ( ) No

Resident's Name: ____

We must have a funeral home preference on file.

Name of Funeral Home Preference: ____

Address: _____________________________________ Phone Number: ____________________

____

Significant Health History: (Major health impairing incidents, diseases, accidents, and chronic disabilities, social and emotional impact): ____

____

____

____

Retirement Date: __________________________ Reason: ______________________________________

Any other comments: ____

____

____

______________________________________ _______________________ _________________

Signature of Person Completing Packet Relationship to Resident Date Completed

CHATUGE REGIONAL NURSING HOME
RESIDENT FINANCIAL AND LEGAL INFORMATION

Resident Name: ____ Date: _________________

Who will be responsible for paying the facility for the service rendered to the resident each month?

____

(Attach a copy of social security card)

____ **Private Pay/ Responsible Party**

Name of Responsible Party: ____________________Relationship to resident: ______________

Address: ________________________________ Home Phone: _____________________

________________________________ Work Phone: ______________________

________________________________ Cell Phone: _______________________

_____ **Private Insurance** (Attach a copy of card front and back and benefits summary)

Name of Insurance Company: ____

Address: ________________________________ Phone Number: ____________________

________________________________ Policy Number: ____________________

________________________________ Effective Date: _____________________

ID Number: _______________ Group Plan ( ) Yes ( ) No Individual Plan ( ) Yes ( ) No

Medicare Supplement Plan: ( ) Yes ( ) No

_____ **Medicaid** (Attach a copy of card, front and back)

Approved? ( ) Yes ( ) No If yes Medicaid Number: ___________________________________

If No, current status: ____

Do you plan to apply for Medicaid? ( ) Yes ( ) No

_____ **Medicare** (Attach a copy of card, front and back)

Medicare #: ____________________________ Effective date of Medicare: ________________

Medicare A ( ) Yes ( ) No Medicare B ( ) Yes ( ) No

Resident's Name: ___________________________________

_____ **Managed Medicare** (Attach a copy of card, front and back)

Plan #: __________________________ Effective date: ________________________

_____ **Veterans Administration (VA) Benefits** (Attach copy of VA information card, front and back)

Do you qualify for VA benefits? ( ) Yes ( ) No

If applicant does not have a legal representative, we need one (1) person designated as a primary "community" contact or otherwise called the "Sponsor." Please give serious thought to which family member or friend will act in this position. This person should accompany applicant on admission.

Name: _____________________________________ Relationship: ____________________

Address: _______________________________ Home Phone: ___________________

_________________________________ Work Number: ___________________

_________________________________ Cell Number: ____________________

Does the Sponsor have Power of Attorney? ( ) Yes ( ) No

Is the Sponsor the legal guardian (granted through the probate court)? ( ) Yes ( ) No

If applicant has the following legal documents, please provide copies: Living Will, Power of Attorney, Legal Guardianship.

Also be advised that the applicant must see his/her physician within the 5 days prior to admission if applicant is a current patient. If applicant is a new patient, he/she must see the physician within 48 hours after being admitted.

CHATUGE REGIONAL HOSPITAL
AND NURSING HOME
PO BOX 509
HIAWASSEE, GEORGIA 30546-0509
www.chatugeregionalhospital.org
Affiliated with Union General Hospital, Inc.

Authorization for Release of Medical Records Information

Resident's Name: _________________________ Date: _____________________

As required by the Health Insurance Portability and Accountability Act of 1996, Union General Hospital, Inc. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

I authorize Union General Hospital, Inc to release from the medical record of:

____

Last Name **First Name** **Middle Name**

____

Date of Birth **Social Security Number**

____

Dates of Treatment

Check the appropriate areas for type of information to be released:

( ) Entire Chart
( ) Discharge Summary
( ) History / Physical
( ) Laboratory Reports
( ) Radiology Reports / Films
( ) Operative Report
( ) Pathology Report
( ) ER Reports
( ) EKG / Heart Tracings
( ) Other:_____________________________

To:

____

Doctor or Facility Name

I understand that I may revoke this consent at any time and that this consent will automatically expire 90 days from the date signed below. This hereby releases the sender of all legal responsibility or liability of the Release of Information described above from my records.

____________________________________ ___________________

Resident / Responsible Party Signature **Date**

____________________________________ __________________________

Relationship to Patient **Witness**

Any disclosure of medical records information by the recipient(s) is prohibited except in the purpose of the disclosure.