



OAKLAND

Lake Orion Nursing and Rehabilitation Center

Admission Application
Smoke Free Environment

Date: Resident's Name: (Last) (First) (MI) (Maiden Name)

Address: City: State: Zip:

County: Date of Birth: Age: Sex: M F

Marital Status: M W D S Phone: Soc. Sec#:

Is Resident a Veteran? Y N Branch: VA#:

Is Spouse a Veteran? Y N Branch: VA#:

Birthplace (state or country): Country of Citizenship:

Religion: Race:

Funeral Home Preference: (Name) (Address) (Phone)

Insurance Information

Medicare # Medicaid# PDP# PCN BIN

Private Insurance: Contract #: Group #:

Third Party insurance:

In Case of Emergency:

Name: Relationship: Phone:()

Address: Phone:()

City: State: Zip:

Name: Relationship: Phone:()

Address: Phone:()

City: State: Zip:

Name: Relationship: Phone:()

Address: Phone:()

City: State: Zip:

Billing To Be Sent To:

Name: Relationship: Phone:()

Address: Phone:()

City: State: Zip:

Patient Currently Resides: Date: From: To:

Last Hospital Name: Date: From: To:

Has Patient Been in Another Skilled Nursing Facility in the Last 60 Days? Y N (If Yes answer below)

Name of Facility: Date: From: To:

Resident's Primary Physician Name: Phone#:

Address: City: Zip:

Lake Orion Nursing and Rehabilitation Center Physician Preference:

Allergies:

Height:_____ Weight:_____ Patient Ambulates with: Self:_____ Wheelchair:_____ Walker:_____

Current Diagnosis:_____

Current Medications:_____

Mental Status(Please Check all that apply) Alert:___ Comotose:___ Cooperative:___

Confused:___ Restless:___ Anxious:___ Combative:___ History of Mental Illness:___

Any specific Behaviors?_____

Please provide us with additional information important in the care for your loved one:_____

History:

Lifetime Occupation:_____

Level of Education Completed: Grade:___ High School:___ Tech/Trade School___ Some College___

Bachelor's Degree:___ Graduate Degree:___

Primary Language:_____

Residential History in the past 5 years: Own Home___ Lived Alone:___ Nursing Home:___ Group Home:___

Assisted Living:___ Mental Health Facility:___

Customary Routine (One year prior to admission)

Stays up late at night (E.G. after 9PM).	Yes___	No___
Naps Regularly during the day (At least one hour).	Yes___	No___
Goes out one or more days a week.	Yes___	No___
Stays Busy with hobbies, reading, or fixed daily routine.	Yes___	No___
Spends most of the time alone or watching TV.	Yes___	No___
Moves independently indoors (with appliance, if used).	Yes___	No___

Eating Patterns

Distinct food preference.	Yes___	No___
Eats between meals all or most days.	Yes___	No___
Use of alcoholic beverages(s) at least weekly.	Yes___	No___

Activities of daily living patterns

In bedclothes most of the day.	Yes___	No___
Waken to toilet all or most days.	Yes___	No___
Has irregular bowel movement pattern.	Yes___	No___
Prefers Showers to bathing.	Yes___	No___
Prefers PM bathing/showers.	Yes___	No___
Has smoked in the past.	Yes___	No___
Is presently a smoker.	Yes___	No___

Social

Daily contact with relatives/close friends. Yes___ No___
 Usually attends church, temple, synagogue, ect. Yes___ No___
 Finds strength in faith. Yes___ No___
 Daily animal companion/presence. Yes___ No___
 Involved in group activities. Yes___ No___

Medical

Does the applicant currently use oxygen? Yes___ No___ If yes, how often: _____
 Does the patient currently require dialysis? Yes___ No___
 Is patient currently in a hospice program? Yes___ No___ If yes, how often: _____
 Does applicant have a tracheotomy? Yes___ No___

Legal Guardian? Yes___ No___ Name: _____ Phone: _____
 Address: _____ City _____ State: _____ Zip: _____
 Power of Attorney? Yes___ No___ Name _____ Phone _____
 Address: _____ City _____ State: _____ Zip: _____
 Power of Attorney Medical Provisions? Yes___ No___ Name _____ Phone _____
 Address: _____ City _____ State: _____ Zip: _____

*Please provide all legal documents, social security card, medicare card and other medical cards to Lake Orion Nursing and Rehabilitation Centre upon admission. Copies will be made and the originals will be returned to you immediately.

Final Disclosure

AS STATED IN THE RIGHTS AND RESPONSIBILITIES ON PAGE 11: "A patient is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations."

Source of income:

\$ _____ Social Security	\$ _____ Savings/Checking
\$ _____ Pension	\$ _____ Certificate of Deposit
\$ _____ Annuity	\$ _____ Mutual Funds
\$ _____ VA	\$ _____ Rental Income
\$ _____ Life Insurance	\$ _____ Other

Debts: Yes___ No___ Amount\$ _____

Application Must be Signed and Dated

Signature of person completing application: _____

Date: _____

MICHIGAN LAW REGARDING NURSING HOME ADMISSION

ACCORDING TO STATE LAW, AS OF JANUARY 1, 1992 OLDER ADULTS MUST BE AFFORDED THE RIGHT TO SIGN THEIR OWN NURSING HOME ADMISSION PAPERS.

THEREFORE, PRIOR TO ALL ADMISSIONS, THE ADMISSION PAPERWORK IS TO BE SIGNED BY THE PERSPECTIVE RESIDENT, OR LEGAL REPRESENTATIVE.

LAKE ORION NURSING & REHAB CENTRE WILL BE HAPPY TO GIVE YOU A COMPLETE ADMISSION PACKET TO PRESENT TO THE PERSPECTIVE RESIDENT. IT CAN BE TAKEN TO THE HOSPITAL OR HOME FOR THE SIGNATURE. THESE DOCUMENTS, AGAIN ACCORDING TO THE STATE LAW, MUST BE WITNESSED BY A NON-FAMILY MEMBER.

ALL APPLICATIONS WILL BE KEPT ON FILE FOR SIX (6) MONTHS