EXTENDED CARE

202 Prospect Drive ¤ Glendive, MT 59330

Resident Profile

Pre-Admission / Admission Information

Glendive Medical Center (GMC) has an open admission policy regardless of race, color, creed, age, national origin, medical diagnosis or handicap. This admission policy is limited only by our ability to properly serve the resident.

Extended Care (EC) has 71 long term care (LTC) beds providing custodial and/or skilled nursing. The EC is staffed with healthcare professionals and managers who strive constantly to make the facility a place where the residents are treated with dignity and respect.

Room rates will be discussed with the prospective resident and his/her responsible party by Social Services. Pre-payment is required upon admission.

Admission procedure is based on the following:

- The Facility must have a current Application for Admission completed by the perspective resident and/or the person who is responsible for handling the financial and/or medical affairs of the prospective resident.
- A current (less than 5 days old) History and Physical from the admitting physician is required.
- Once the above information has been received, the application will be considered for admission. In rare circumstances this form may be completed at time of admission.
- When a bed becomes available for an approved resident, the responsible party will be notified and admission arrangements will be made at that time. (All residents will be admitted at a pre-arranged time during regular business hours).
- **The Interdisciplinary Team requests that the potential resident/responsible party bring copies of any legal documents, which include Financial Durable Power of Attorney, Medical Durable Power of Attorney, Guardianship, Advance Directives, Living Wills, etc.**
- If you have any questions, please feel free to contact Social Services

at (406) 345-3326, Monday through Friday, between the hours of 8:00 am and 5:00 pm.

PLEASE NOTE THAT COMPLETION OF THE PRE-ADMISSION FORM DOES NOT GUARANTEE PLACEMENT AT THE EXTENDED CARE.

APPLICANT / RESIDENT PROFILE

APPLICANT/RESIDENT INFORMATION:			
Name:	DOB:	Age:	Sex:
Address:			
City:	State:	Zip:	Phone: ( )
Religion:	Marital Status: S M W D	Birth Place:	
Social Security #:			
Attending Physician Name:		Physician Phone #:	
Address:		Last Seen by Dr:	

HOSPITALIZATION:		
Have you been hospitalized in the last 12 months? ☐ Yes ☐ No If **Yes**, please complete the following information:		
Hospital: (Most recent)	Admit Date:	Discharge Date:
Nursing Home: (Most recent)	Admit Date:	Discharge Date:
Current residence:		Admit Date:

IN CASE OF EMERGENCY, NOTIFY: (Medical POA / Guardian)			
(1) Name:		Relationship:	
Home Phone: ( )	Business Phone: ( )	Cell Phone: ( )	
Address:	City:	State:	Zip:
(2) Name:		Relationship:	
Home Phone: ( )	Business Phone: ( )	Cell Phone: ( )	
Address:	City:	State:	Zip:

RESPONSIBLE PARTY: (Financial POA) (Bills will be sent here)			
Name:		Relationship:	
Home Phone: ( )		Business Phone: ( )	
Address:	City:	State:	Zip:

LEGAL DOCUMENTATION:			
Do you have the following documents? (Please send copies with the application)			
☐ Durable Power of Attorney	☐ Durable Medical Power of Attorney	☐ Living Will	☐ Guardianship
☐ Conservator	☐ Do Not Resuscitate/POLST	☐ Other Advance Directives	☐ Long Term Care Insurance
☐ Prescription Plan	☐ Medicare Card	☐ Medicaid	☐ Medicare Supplement

APPLICANT/RESIDENT SOCIAL EVALUATION

APPLICANT/RESIDENT INFORMATION:		
Applicant/Resident Likes To Be Called (Nickname):		
Current Living Arrangements: ☐ House ☐ Apartment ☐ Other:		
Do You Live Alone? ☐ Yes ☐ No Explain:		
Previous Occupation:	Education:	Veteran? ☐ Yes ☐ No
Cultural Background, if any:	Spiritual/Religious Preference:	
Is This: ☐ Short Term ☐ Long Term ☐ Other ______________________________		

FAMILY MEMBERS/Special Interests:	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Spouse Name: ☐ Living, Anniversary Date: ☐ Deceased, Date:	
Children: (If more, list on back of form)	
Name:	Phone: ( )
Address:	
Name:	Phone: ( )
Address:	
Name:	Phone: ( )
Address:	
Name:	Phone: ( )
Address:	
Parents – Father's name:	Mother's name (& Maiden name) /
Occupations:	# of Siblings:
# of Grandchildren	# of Great Grandchildren
Hobbies:	
Club Memberships:	
Recreational Activities:	
Other Interests:	

PSYCHOSOCIAL:
Have you been informed of admission to the nursing home? ☐ Yes ☐ No
How do you feel about your current status?
How does your family feel about your current status?
Do you have any financial concerns?
Have you had any recent losses? ☐ No ☐ Yes Please Explain:
Disability(s) ☐ No ☐ Yes If yes, how do you feel about your disability?
Current reason/need for placement:

CURRENT PHYSICAL HEALTH PROBLEMS:			
☐ Alzheimer's	☐ Diabetes	☐ Hypertension	☐ Pain
☐ Dementia	☐ Heart Disease	☐ Obesity	☐ Contractures
☐ Hearing Impaired	☐ Limited Vision	☐ Seizure Disorder	☐ Paralysis
☐ Bowel Incontinence	☐ Respiratory	☐ Cancer	☐ Speech Impaired
☐ Parkinson's	☐ Blind	☐ Fracture	☐ CVA / Stroke
☐ Arthritis	☐ Feeding Tube	☐ Urine Incontinence	☐ Gastrointestinal Disorder
☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Decubitus Ulcer	☐ Catheter Use	☐ Infections (UTI, Respiratory, etc.)	
☐ Hallucinations	☐ Smoker	☐ Alcohol Consumption	
Other:			
Comments:			

WHICH OF THE FOLLOWING BEST DESCRIBES THE APPLICANT'S ABILITY TO WALK:	
☐ Fully independent	☐ Uses wheelchair independently
☐ Unsteady	☐ Uses wheelchair with assistance
☐ Uses cane or walker independently	☐ Uses gait belt
☐ Uses cane or walker **with** assistance: ☐ Yes ☐ No	☐ Total assistance with transfers
Falls History: ☐ Yes ☐ No Most Recent Fall Date: How many falls in last month?	
Comments:	

WHICH OF THE FOLLOWING BEST DESCRIBES THE APPLICANT'S / RESIDENT'S BEHAVIORAL STATUS:		
☐ Oriented to person	☐ Able to verbalize feelings	☐ Crying
☐ Oriented to place	☐ Confused	☐ Anxious Meds?
☐ Oriented to time	☐ Forgetful	☐ Nervous Meds?
☐ Oriented to situation	☐ Able to make eye contact	☐ Noisy
☐ Opens eyes but does not respond	☐ Aggressive ☐ Verbal ☐ Physical	☐ Yells out
☐ Unresponsive to stimuli	☐ Angry	☐ Wanders
☐ Sexually inappropriate behavior	☐ Agitated	☐ Depression Meds?
☐ History of psychiatric treatment Where? When? Meds?		
Have meds for anxiety or depression been changed? Why?		
Comments:		

PERSONAL CARE ACTIVITIES: Has resident changed in any of the following areas in last 90 days? ☐ Yes ☐ No

	Fully Independent	Needs Supervision	Needs Some Physical Assist	Needs Much Physical Assist	Needs Total Care
Bathing	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Toilet Use	☐	☐	☐	☐	☐
Bed Mobility	☐	☐	☐	☐	☐
Personal Hygiene	☐	☐	☐	☐	☐

Hygiene Products ____ Catheter ☐ / Colostomy ☐

NUTRITIONAL STATUS: Height: ___ft ___in Usual body weight _____lbs

Normal meal times: Breakfast ____ am Lunch _____ am/pm Dinner _____ pm Snack(s) ________am/pm

Likes:	Dislikes:
Special Diet (Specify):	Weight change in last 6 months? #'s gained ___ #'s lost __
Adaptive Eating Equipment (Specify):	Food Allergies / Intolerances:

Appetite: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Use of Supplement (Specify):	Religious/Ethnic Food Preferences:

ORAL CARE:

☐ Own Teeth ☐ Full Dentures ☐ Partial Dentures ☐ Upper Dentures ☐ Lower Dentures

☐ Missing Teeth ☐ Dental Cavities Last Dental Exam Date: __________ Difficulty: ☐ Chewing ☐ Swallowing

Name of Dentist:	Address/Phone:

VISION:

☐ Normal Vision ☐ Wears Glasses ☐ Limited (Large Print) ☐ Legally Blind Last Exam: _________

Name of Eye Doctor:	Address/Phone:

HEARING:

☐ Normal Hearing ☐ Hearing Loss ☐ Right Ear ☐ Left Ear ☐ Hearing Aide Battery size ________ ☐ Right Ear ☐ Left Ear

Name of Audiologist:	Address/Phone:

APPLICANT/RESIDENT PHYSICAL HEALTH HISTORY

SOCIALIZATION / ACTIVITY INTERESTS:

☐ Prefers to be Alone	☐ Enjoys Being Around Others	☐ Occasionally Enjoys Being Around Others

Normal time to waken: ______ am   Normal bedtime: ______ pm   Naps: ☐ Yes ☐ No   Time(s) of Day: ___am /___pm

Bath: ☐ Tub   ☐ Shower   ☐ A.M.   ☐ P.M.

CLOTHING:

Clothing Sizes & Preferences: Pants: Shirt: Shoes: Underwear:

Comments:

PHARMACEUTICAL INFORMATION

Currently Using Oxygen? ☐ Yes ☐ No   Oxygen Co:____________________

Allergies (List): ____

Prescription Drug Plan? ____

We may ask you to switch plans if we are not contracted.

Current Medication List

Medication/Drug	Amount/Dosage (mg,etc.)	Is it taken by mouth or injection?	What time?

MORTUARY:

Have pre-arrangements been made? ☐ Yes ☐ No			
Mortuary Name:		Phone: ( )	
Address:	City:	State:	Zip:

Any other information you feel may be important: ____

____

____

Completed By:______________________________________ **Relationship:** ________________ **Date:**_______________

Witness: ____ **Date:**_______________

APPLICANT / RESIDENT PHYSICAL HEALTH HISTORY

MANAGEMENT EVALUATION:	
FOR OFFICE USE ONLY*	
Evaluated by:	Date: