Mason County's Oakview MEDICAL CARE FACILITY

ADMISSIONS APPLICATION

INFORMATION & INSTRUCTIONS

General

Oakview's receipt of this application does not guarantee placement, however, it confirms that the applicant's information has been received for admission review and an Oakview staff member will be in touch with you regarding our waiting list and admission procedure. Thank you in advance for your interest, input and cooperation.

Pre-Admission Screening

A pre-admission screening is required by Federal OBRA regulations for individuals seeking to place a resident in a nursing facility who have a serious mental illness or a developmental disability. The applicant's primary care physician will need to assist with completing the necessary pre-admission screening paperwork (commonly referred to as PASARR or Forms 3877 and 3878). Time delays are to be expected if it is determined that a full Level II Assessment is needed.

Chest X-Rays

A chest x-ray must only be completed 90 days or less prior to the date of admission to a skilled nursing facility if the resident is a known positive reactor for tuberculosis. If an x-ray is needed and this has not already been done, you will need to contact your physician regarding this matter.

Non-Smoking Facility & Campus

Oakview Medical Care Facility, including the Sutter Living Center, is a non-smoking facility and campus.

Application Submission

Please complete this application and return to Oakview

By Mail: Attn: Admissions
Oakview Medical Care Facility
1001 Diana Street
Ludington, MI 49431

or

By Fax: 231.843.7899

Contact Information

If you have questions regarding the completion of this form, please contact our Admissions Office at: 231.845.5185, ext. 227.

Mason County's Oakview MEDICAL CARE FACILITY

ADMISSIONS APPLICATION

PLEASE COMPLETE PAGES 2 - 4 IN FULL

PART A. APPLICANT PERSONAL INFORMATION

Applicant's Full Name (Last, First, MI)			Date
Social Security #	Birth Date	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Legal Address (Street / Box Number)			Contact Phone
City	State	Zip	County of Residence

Currently residing (Please check one)

- ☐ Adult Foster Care: _____
- ☐ Assisted Living: _____
- ☐ Home/Independent
- ☐ With Family Member: _____
- ☐ Hospital/Rehabilitation: _____
- ☐ Nursing Home: _____
- ☐ Psychiatric Facility: _____
- ☐ Other (Please list): _____

PART B. APPLICANT BACKGROUND

Military

Is Applicant a Veteran? ☐ Yes ☐ No

Is Spouse a Veteran? ☐ Yes ☐ No

If yes, spouse's name & DOB:

If yes to either, branch of service: ☐ Army ☐ Navy ☐ Airforce ☐ USMC ☐ Coast Guard

PART C. LEGAL INFORMATION

Does Applicant have any of the following?

(Please check all that apply and ***send or attach copies***)

- ☐ Court Appointed Conservator
- ☐ Court Appointed Guardian
- ☐ Financial DPOA
- ☐ Health Care DPOA
- ☐ Living Will
- ☐ Other Written Advance Directives (regarding life support issues)

PART D. MEDICAL INFORMATION

Current Primary Care Physician Name		Phone Number
Physician Office/Hospital	Date of Last Hospital Admission	

Ever been admitted to a Nursing Home? ☐ Yes ☐ No

Name of Nursing Home	Dates of Nursing Home Stay	Contact Number

PART D. MEDICAL INFORMATION (continued)

Is the prospective resident aware of this application?	☐ Yes ☐ No
Does the prospective resident use tobacco products?	☐ Yes ☐ No
If yes, is applicant agreeable to quitting?	☐ Yes ☐ No ☐ N/A
Is resident a known positive reactor for tuberculosis?	☐ Yes ☐ No
If yes, date of last chest x-ray:	☐ N/A Date:

Does the prospective resident have a Dementia diagnosis? ☐ Yes ☐ No

If yes, please list the diagnosing Physician:

Current Diagnoses (Please select all that apply)

☐ Arthritis	☐ Diabetes	☐ Hyper/Hypo-thyroid	☐ Osteoporosis
☐ Cognitive Deficit	☐ Epilepsy	☐ Hyperlipidemia	☐ Parkinson's
☐ Congestive Heart	☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ COPD	☐ High/Low BP	☐ Macular Degeneration	☐ Other (Please list below):
☐ Cancer	☐ Huntington's	☐ Multiple Sclerosis	_____
Type: _____			_____

Please list Other diagnosis (if applicable):

Current Medications & Dosages (If necessary, please include additional medications on a separate page)

Known Allergies (Please list)

Does applicant currently have or receive the following? (Check all that apply)	☐ Amputation ☐ Peg tube/ JG tube ☐ Catheter ☐ Routine Injections ☐ Dialysis ☐ Tracheotomy ☐ Hospice Services ☐ Ventilator or Respirator ☐ Ostomy bag ☐ Wound Care`
Any current evidence or history of? (Check all that apply)	☐ Behavioral Problems / Issues ☐ Confusion ☐ Dementia or Alzheimer's Dementia ☐ Developmental Disability / Mental Retardation ☐ Hallucinations / Paranoia ☐ Mental Illness ☐ Substance Abuse

If you checked any of the above, please give a brief explanation:

Mason County's Oakview MEDICAL CARE FACILITY

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PART E. INSURANCE INFORMATION

IMPORTANT: Please provide or attach copies of ALL INSURANCE CARDS (front and back)

Please check any of the following that the applicant currently receives:

☐ Medicaid	Medicaid Number	
☐ Medicare Part A	Card Date	Medicare Number
☐ Medicare Part B	Card Date	
☐ Medicare Part C (Medicare Advantage)	Card Date	Plan Number
☐ Medicare Part D (Prescription)	Prescription Plan Name	Prescription Plan Number
☐ SSI Recipient		
☐ Veteran's Benefits	Please list beneficiary information	

Have you, or will you be, applying for Michigan Medicaid?	☐ Yes ☐ No
If yes, please list date applied:	☐ N/A Date:

Other Insurance

Type of Insurance		Name Listed on Insurance Card	
State	Contract Number	Group Number	Service Code
Insurance Company's Address			

PART F. CONTACT PERSONS

1.	First and Last Name	Relationship
	Mailing Address	
	Email Address	☐ Home Phone ☐ Cell Phone
2.	First and Last Name	Relationship
	Mailing Address	
	Email Address	☐ Home Phone ☐ Cell Phone

Name of person submitting application	Relationship to prospective resident

For Admissions Office Use Only

Placement:	☐ **OMCF Skilled Nursing Unit**	☐ **SLC Alzheimer's/Dementia Unit**	☐ **Unknown**

Mason County's Oakview MEDICAL CARE FACILITY

RESIDENT ADMISSION/TRANSFER INFORMATION

Name:			DOB:		Age:
Sex: ☐ M ☐ F	MS: ☐ S ☐ M ☐ D ☐ W		Religion:		SS#:
Address:			ST:	ZIP:	C:
Contact:			H:		W:
Guardian:			H:		W:
MDPOA:			H:		W:
Transfer from:			DOH:		
Transfer to: **OAKVIEW MEDICAL CARE FACILITY**			DOT:		
Medicare #:			Medicaid:		
Commercial:			Policy #:		

ASSESSMENT

Reason for transfer:					
Vital Signs	T:	P:	BP:	WT:	HT:
Allergies:			Food Allergies:		
Speech	☐ Normal	☐ Impaired	☐ Aphasic		
Hearing	☐ Normal	☐ Deaf	☐ HOH	☐ Aides	☐ Rt ☐ Lt
Sight	☐ Normal	☐ Impaired	☐ Blind	☐ Glasses	☐ Contacts
Mental Status	☐ Alert ☐ Forgetful	☐ Oriented ☐ Dementia	(Self:	Time:	Place:)
Feeding	☐ Independent	☐ Setup/Assist	☐ Feed	☐ Tube (NG:	JT:)
Dressing	☐ Independent	☐ Assist	☐ Total Assist		
Bathing	☐ Independent	☐ Assist	☐ Total Assist		
Bladder	☐ Continent	☐ Incontinent	☐ Catheter	☐ Inserted	☐ D/C
Bowel	☐ Continent	☐ Incontinent	☐ Colostomy	Date of last BM:	
Activity	☐ Ambulate	☐ Independent	☐ Assist: ☐ (1) ☐ (2)	☐ SCB ☐ BSC	☐ BRP ☐ Chair
Assistive Devices	☐ Walker	☐ Cane	☐ Crutches	☐ W/C	☐ Braces ☐ Prosthesis
Pace Maker	☐ Yes	☐ No			
Skin Integrity	☐ Intact	☐ Open Area	Stage: ☐ I	☐ II	☐ III ☐ IV
	Location/Size of Wound:				
	Areas of Bruising:				

Physician or Nurse Signature	**Date**

Mason County's Oakview MEDICAL CARE FACILITY

PHYSICIAN ORDERS

Patient Name		
Diagnosis		
Surgical Procedure(s) and Date(s):		
Admit patient to:	**OAKVIEW MEDICAL CARE FACILITY**	
Informed of total health status:	Patient ☐ YES ☐ NO	Family ☐ YES ☐ NO
Patient Cognition	Capable of signing documents and adequately communicating understanding of Rights & Responsibilities: ☐ YES ☐ NO If NO, state reasons: _____	
Infection or Communicable Disease	Evidence of? ☐ YES ☐ NO Reason: _____	
Rehabilitation	☐ PT ☐ OT ☐ Speech Potential to return to prior level of function: ☐ GOOD ☐ FAIR ☐ POOR	
Diet Orders	Was patient on any special diet or diet textures in last 7 days? ☐ YES ☐ NO If YES, explain: _____	
	Current Diet Orders: ☐ Regular ☐ Mechanical Soft ☐ Pureed ☐ Carb Controlled ☐ Other: _____	
	Was patient on feeding tube/TPN/IV in last 7 days? ☐ YES ☐ NO If YES, explain: _____	
Activity Level	☐ Ambulate ☐ Independent ☐ Assist ☐ (1) ☐ (2) ☐ SCB ☐ BSC ☐ BRP ☐ Chair	
Elimination	Bladder Train: ☐ YES ☐ NO ☐ Catheter Inserted FR#: _____ Bowel Enema: ☐ Fleets ☐ Supp. Dulcolax ☐ Per Facility protocol	
Colostomy		
Personal Hygiene	☐ Bed Bath ☐ Tub ☐ Shower	
Respiratory	☐ Oxygen TX: _____	

Mason County's Oakview MEDICAL CARE FACILITY

PHYSICIAN ORDERS

Patient Name	
TB	May have TB skin test? ☐ YES ☐ NO If NO, indicate reason:_____ Previously treated for TB? ☐ YES ☐ NO Xray evidence of inactive TB:_____ Known positive TB skin test:_____ Other:
Flu Vaccine	May have flu vaccine during season? ☐ YES ☐ NO
Pneumovax	May have pneumovax vaccine? ☐ YES ☐ NO Vaccine previously given: _____
Med Pass	May go out on pass with medications? ☐ YES ☐NO
Activities	May participate in Activities per Activity Plan of Care? ☐ YES ☐ NO ☐ N/A
Physician	Who will follow upon transfer?
Labs	
X-Rays	
Medication List	☐ List including dose, route, frequency & Dx printed and attached; OR ☐ List completed below

Medication	Dose	Route	Frequency	Dx for Medication

Additional Orders

Physician Signature	Date

Mason County's Oakview MEDICAL CARE FACILITY

CLINICAL HISTORY & PHYSICAL EXAMINATION

A Clinical History & Physical Examination must be current within 48 hours following admission or 72 hours in the case of a Friday admission. If the physician completes this form **and** submits the last History & Physical that was completed, this completed form will suffice as a current and up-to-date History & Physical Examination.

Patient Name	
History	
Vital Signs	
Eyes	
Nose / Throat	
Neck	
Lungs	
Breasts	
Heart	
Abdomen	
Rectal	
Neuromuscular	
Bones and Joints	
Lymph Glands	
Skin	

Physician Signature	Date

Mason County's Oakview MEDICAL CARE FACILITY

SUTTER LIVING CENTER
MISSION & CRITERIA ACKNOWLEDGMENT

MISSION

The mission of Oakview's Alzheimer's Unit, The Sutter Living Center (SLC) is to provide holistic care to those residents afflicted with Alzheimer's disease or related conditions by providing a safe environment where residents will be able to function at their optimal level while being a part of their living environment. This care will not only focus on the resident's physical health but also their emotional and psychosocial needs.

CRITERIA

The SLC is a transitional unit; residents must meet specific criteria for admission and will be discharged with an irreversible decline in condition.

SECURITY & RESIDENT ACCESS

The SLC is a locked, secure environment providing controlled access and egress by staff and visitors.

ACKNOWLEDGMENT

I have read the above statements and understand the Mission and Criteria of the SLC. I also understand that there may come a time when my loved one no longer meets these criteria and will need to be transitioned out of the SLC and into Oakview's skilled nursing unit.

Resident Name	Resident ID Number
Resident's Responsible Party Signature	Date
Witness Signature	Date