

Applicant's Name: _____

Date: _____

Rosary Hill Home

600 Linda Avenue

Hawthorne, NY 10532

Tel: (914) 769-0114 Fax: (914) 769-3916

APPLICATION AND PRE-ADMISSION FORM

Please Read All Information Carefully

All Questions MUST Be Answered Before the Application Can Be Reviewed and Processed

Requirements for Admission to Rosary Hill Home:

Documented proof of a diagnosis of incurable cancer is required. This may be a Pathology Report, a CAT Scan, a Biopsy Report, or other requested information.

Rosary Hill Home is a free home for those who are financially UNABLE to afford nursing care elsewhere. This means:

- the patient has no insurance coverage
- if the patient has insurance coverage, such coverage is not adequate to cover the cost of a stay in a nursing facility
- the patient does not have other assets that would cover the cost of nursing care

Rosary Hill Home accepts no payment of any kind, including Medicare, Medicaid, private insurance or private pay. Financial need is a requirement for admission.

Patients and families must be informed that the care provided by Rosary Hill Home is palliative, not curative. All treatments must be completed before the patient is accepted. Medications and all ancillary orders will be prescribed by our physicians.

Do Not Resuscitate - As only persons with incurable cancer are admitted to Rosary Hill Home, and as Rosary Hill Home provides only palliative care, all patients must submit a valid "Do Not Resuscitate" (DNR) Order prior to admission.

Palliative Care is a concept of care which employs medical and nursing care as well as specific ancillary services, when indicated, whose primary objective is the comfort and overall well-being of the incurable/terminal individual. No treatment is employed which would overburden the individual, yet full support is offered for basic physical needs as well as spiritual, psychological, and emotional needs. Individuals, while experiencing similar diagnoses, may have different needs or symptoms associated with their disease and secondary diagnoses, hence personalized medical or nursing plans of care based on individual needs and symptoms are developed.

Rosary Hill Home complies with all applicable federal, state, and local civil and human rights laws with regard to employment and provision of services. Patients are welcome regardless of age, color, creed, sex, national origin, handicap, or marital state.

I AM AWARE OF AND ACCEPT THE POLICIES STATED ABOVE.

Signature of patient / responsible person required for admission:

Signature _____

Relationship _____

Name (Printed) _____

Home Phone Number _____

Address _____

Work Phone Number _____

Applicant's Name: _____
Last First Middle

Date of Birth: _____ Male/Female: _____
Month / Day / Year

Address: _____ Race: _____
Number & Street Apt. Number Religion: _____

City State ZIP Code Marital Status: _____
Height: _____

Social Security Number: _____ Weight: _____

Veteran: _____ Branch of Service: _____ Years: _____
Yes/No Ambulatory: _____

Highest Level of Education: _____ Lived Alone: _____ (Yes/No)

Admitted From: _____ Occupation: _____

Location: _____ Place of Birth: _____

If admitted from home, date of most recent hospitalization: _____

Family / Responsible Person Contacts

* Please indicate if the person listed as a contact has Power of Attorney or other special legal relationship to the patient.

Primary Contact

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. Number City State ZIP Code

Phone Number Home: _____ Work: _____ Beeper: _____

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. Number City State ZIP Code

Phone Number Home: _____ Work: _____ Beeper: _____

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. Number City State ZIP Code

Phone Number Home: _____ Work: _____ Beeper: _____

Hospital Use Only

Admission Date: _____ Admission Number: _____
Coming by: _____ Room Assigned: _____

Nursing Assessment

Applicant's Name: _____ Age: _____ Sex: _____

1. Present Mental Status

Alert _____ Disoriented _____ Noisy _____ Depressed _____ Abusive _____
Oriented _____ Anxious _____ Quiet _____ Withdrawn _____ Noncompliant _____
Decisions Consistent & Reasonable _____ Lethargic _____ Suspicious _____ Unresponsive _____

Comments _____

2. Activity / Mobility

Dependent for all position changes _____	<u>Transfers</u> Full Assist _____	<u>Locomotion</u> Gerichair _____	Other _____
Bedfast _____	Limited Assist _____	Wheelchair _____	
OOB to chair _____	Supervision _____	Walker _____	
Ambulatory _____	OOB ad lib _____	Cane _____	

3. Diet / Nutrition

Type of Diet _____

Chewing or Swallowing Problems _____

NPO _____

Artificial Nutrition (PEG, TPN, PPN, etc.) or Hydration (IV) explain _____

Height _____ Weight _____ Usual Weight Prior to Illness _____

4. List of All Allergies _____

5. Communication

Language Spoken: English _____ Other (specify) _____
Aphasia _____ Speech Slurred or Garbled _____ Noncommunicative _____

6. Special Needs / Appliances / Equipment

Oxygen (mode of delivery and l/min) _____	Incontinent of Urine _____
Tracheostomy (size & make) _____	Foley Catheter _____
Suction _____	Incontinent of Feces _____
Humidifier _____	Ostomy (specify) _____
Nebulizer _____	

Wound Care (explain in detail site, origin, procedure) _____

Other Issues / Needs _____

7. Restraints (describe and explain) _____

8. Smoking Currently Smokes _____ Packs per day _____

9. History of Alcohol or Drug Abuse (explain) _____

Nurse / Caregiver Signature _____

Print Name _____

Telephone Number _____

