**ADMISSION QUESTIONNAIRE**

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| --- | --- | --- |
| DATE: |  |  |
| PT NAME: |  | DOB: \_ |
| KAISER ID: | \_ | SS# |
| MEDICAL ID#: |  | HOMELESS? YES NO |
| PT PHONE # |  | OK TO CONTACT? YES NO |

PATIENT IS VOLUNTARY AND AGREES TO PARTICIPATE IN OUR PROGRAM AND ABIDE BY OUR GUIDELINES? YES NO

# DC PLANNING:

PT CURRENT ADDRESS:

WILL PT BE RETURNING TO (CURRENT) ADDRESS UPON DISCHARGE? YES NO

RETURNING HOME ALONE? YES NO

IF RETURNING HOME DOES THE PATIENT HAVE FAMILY AND/OR COMMUNITY SUPPORT? YES NO

NAME OF CARE PROVIDERS:

PHONE#

PHONE#

OK TO CONTACT CARE PROVIDER (S)? YES NO

WILL A HIGHER LEVEL OF CARE POSSIBLY BE NEEDED UPON DISCHARGE? YES NO IHSS IN PLACE: YES NO IHSS SERVICES NEEDED: YES NO

DOES PATIENT HAVE MEDI-CAL: YES NO IF YES FOR WHICH COUNTY:

PATIENTS INCOME: SSI: DISABILITY:

RETIREMENT: OTHER:

IS PATIENT CONSERVED? YES NO

CONSERVATOR NAME: PHONE#:

DOES PATIENT HAVE A PAYEE? YES NO

PAYEE’S NAME: \_ PHONE#:

# ADMISSION ADL-DME NEEDS:

HEIGHT:

WEIGHT:

INDEPENDENT: YES NO DATE OF LAST FALL IF APPLICABLE: N/A ASSISTANCE NEEDED WITH: BATHING: YES NO DRESSING: YES NO

TRANSFERING: YES NO AMBULATING: YES NO ASSISTIVE DEVICES USED:

DME NEEDS PRIOR TO ADMISSION:

LAST COVID TEST WITHIN 72 HOURS?

RESULTS? POSITIVE NEGATIVE

RESULTS INCLUDED WITH REFERRAL: YES NO (PLEASE INCLUDE) COVID VACCINE RECEIVED? MANUFACTURER:

COUNTY RECEIVED: 1ST INJECTION DATE: \_ 2ND INJECTION DATE: Booster Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIDE EFFECTS?

DATE OF LAST PPD PLACED: RESULTS: POS NEG CHEST XRAY PROVIDED RESULTS OF PPD TEST OR XRAY RESULTS INCLUDED WITH REFERRAL? YES NO (PLEASE INCLUDE)

ANY CURRENT INFECTIOUS PROCESS/DISEASE(S)? YES NO IF YES PLEASE LIST TYPE AND TREATMENT BELOW

ARE CONTROLLED MEDICATIONS BEING ADMINISTERED?

CONTROLLED MED LIST:

THANK YOU FOR YOUR ASSISTANCE! THIS INFORMATION IS VERY HELPFUL IN PROPERLY PREPARING FOR AN ADMISSION AND ASSISTS WITH PLACEMENT UPON DISCHARGE IF ASSISTANCE IS NEEDED. IF YOU HAVE ANY FURTHER QUESTIONS FOR OUR STAFF MEMBERS, PLEASE FEEL FREE TO CALL ANYTIME.