THE WELTY HOME LC

21 Washington Avenue
Wheeling, WV 26003
Phone: (304) 242-5233
Fax: (304) 230-1132

APPLICATION FOR ADMISSION

It is a condition for the admission to The Welty Home LC that full and complete answers be made to the following questions. The applicant certifies that all representations made herein are true. If admitted to residency, this application becomes part of the agreement with The Welty Home LC.

1. Name in Full_____

2. Present Address _____
(Street, City, State and Zip Code)

3. Address for the past five years_____
(Street, City, State and Zip Code)

4. Current Phone Number_____

5. Date of Birth_____ Place of Birth _____

6. Who referred you to Welty Home? _____

7. Social Security Number_____

8. Medicare Number _____ Part A ____Part B _____

9. Supplemental Insurance Company:
Name:_____

Mailing Address:_____

Policy ID Number_____

10. Lifetime Occupation:_____

11. Hobbies or amusements you enjoy: _____
_____

12. Legal Civil Status: Single:_____
Married _____ What Year?_____
Widowed_____ What Year?_____
Divorced_____ What Year?_____
Separated_____ What Year?_____

13. Spouse's Name:_____
If living, spouse's address_____

14. How many children did you have?_____
If living, please list current name, address and phone number(s).

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

15. How many brothers_____ and sisters_____ did you have?
If living, please list current name, address and phone number.

_____ _____ _____
_____ _____ _____
_____ _____ _____

16. If you have no children, brothers or sisters, please list the names, addresses and phone numbers of your nearest relatives.

_____ _____ _____

_____ _____ _____

17. Names and addresses of other interested parties (e.g. Power-of-Attorney)

_____ _____ _____

_____ _____ _____

18. Person(s) to be notified in case of serious illness or death. List name, phone number(s), address and relationship.

_____ _____ _____ _____

19. Religious Preference: _____

Church Name (if any) & phone number: _____

20. Funeral Home: (Name & Phone number) _____
_____

21. Do you agree to take the physician's examination required of every applicant prior to admission?_____

22. Do you understand that if the examination indicates any substantial physical or mental disability or impairment, you are not eligible for admission?_____

23. Do you understand that The Welty Home LC assumes no financial responsibility for medical care, hospitalization, medicines, vision, dental, or other health care services? _____

24. Do you understand that Welty Home LC assumes no responsibility for funeral or burial expenses?_____

25. Do you understand that if you become disabled and/or require nursing services you may be moved to a hospital, nursing home, or other appropriate facility?
_____

26. Have you carefully read the rules and regulations of the Home? _____
Do you agree to abide by these rules?_____

27. Do you understand that your residency may be terminated upon 30 days notice for failure to abide by these rules or for other good cause?_____

_____

Signature of Applicant Date

THE WELTY HOME LC

Medical History Form

Date_____

Name: _____

Address: _____

_____

Phone Number: _____

Birthdate: _____ **Age:** _____

Primary Medical Doctor_____
Address & Phone Number_____

1. To the best of your knowledge are you in good health? _____

2. Do you have any disability chronic illness or disease? _____
Explain_____

3. How often do you see your regular physician? _____

4. Who is your Medical Power of Attorney? _____
Do you have a Living Will? _____

5. Do you have any medical allergies? _____
Please list medication(s) and type of reaction_____
_____

6. Do you have any food allergies? _____
Please list food and type of reaction_____
_____

7. Are you on a special diet? _____
Ordered by a doctor_____
Reason for _____
Do you have any other special dietary needs? _____

8. Do you use Oxygen or breathing treatments? _____
What home care agency do you use? _____

9. Do you exercise?_____ **How often**_____ **What kind**_____

10. Do you use:

Coffee? _____ How much? _____
Tea? _____ How much? _____
Water? _____ How much? _____
Alcohol? _____ How often? _____
Tobacco? _____ How much per day? _____
Laxatives? _____ How often? _____ Kind?_____

11. How frequently do you move your bowels?_____
Do you have problems with your bowels? (Diarrhea, constipation, etc.) _____
If yes, describe: _____
Problems with bladder control? (describe) _____
Do you use incontinent briefs? _____

12. Have you had a blood transfusion? _____When?_____
Reason:_____

13. Do you use/have: (check all that apply)

Glasses _____ Contact lenses_____ Cornea implant _____ Artificial eye _____
Dentures: Upper_____ Lower_____ Bridge_____ Tooth implant_____
Hearing aides: Left _____ Right _____ How often is battery changed? _____
Pacemaker_____ Implanted Defibrillator _____ Joint replacement _____
Cane_____ Walker_____

14. Current prescription medication:

Date Prescribed:	Name of Medicine:	Dosage:	Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional medications may be listed on back of page.

15. Over the counter drugs:

_____
_____
_____

16. Do you take the flu shot? _____

Have you had the pneumonia shot? (If yes, when?)_____

17. When was your last tetanus shot? (approximately) _____

18. In case of an emergency, which hospital do you wish to use?_____

19. Please check ( ) any of the following medical problems that you have had and CIRCLE those conditions for which you are being treated at present.

Thyroid problem	**Tumors**	**Hiatal Hernia**
Diabetes	**Cancer**	**Gallbladder problems**
Kidney problem	**Hearing loss**	**Arthritis**
Urinary problems	**Visual impairment**	**Rheumatoid Arthritis**
Hepatitis	**Glaucoma**	**Back problem**
High blood pressure	**Cataract(s)**	**Joint swelling**
Stroke (CVA)	**Blindness**	**Paralysis**
Heart Attack	**Headaches**	**Gait disturbance**
Chest Pain (Angina)	**Seizures**	**Parkinson's disease**
Heart Failure (CHF)	**Epilepsy**	**Multiple Sclerosis**
Swollen Ankles	**Bleeding Tendency**	**Skin problem**
Shortness of breath	**Nosebleeds**	**Leg Ulcer**
Wheezing	**Sinus problem**	**Varicose Veins**
Asthma	**Stomach problems**	**Thrombophlebitis**
Dizziness	**Ulcer**	**Speech Impairment**
Fainting spells	**Diarrhea**	**Vaginal Discharge**
Low Blood (Anemia)	**Constipation**	**Prostate Trouble**
Heart Murmur	**Diverticulitis**	**Hernia (groin)**
Rheumatic Fever	**Hemorrhoids**	**Depression**
Tuberculosis (TB)	**Hernia (abdominal)**	**Anxiety Attacks**

20. Please explain any other illness not noted above:

_____

_____

21. Please list past surgeries and give (approximate) date of each:

_____

_____

22. What Pharmacy will you use? You must choose one and set up account by admission day. (Even if you have mail order, we must have a local pharmacy that delivers.)

_____Elm Grove Pharmacy (formerly Medicine Shoppe)
_____National Road Medicine Shop (Med RX)
_____Gompers

23. Please list all of your doctors—name, address, and phone number:

Medical doctor:

_____

_____

Dentist: (If no dentist, please write "NONE")

_____

_____

Eye:

_____

_____

Ear:

_____

_____

Surgeon:

_____

_____

Psychiatrist/psychologist:

_____

_____

Podiatrist:

_____

_____

Medical specialists:

_____

_____

Medical specialists:

_____

_____

_____

Signature **Date**

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Medical/Functional Status

(To be completed by physician)

Name:_____
Address:_____
Date of birth:_____

1. Diagnosis and pertinent family history:

_____
_____
_____

2. Medical Conditions/Symptoms (Please grade: 1 for mild, 2 for moderate, 3 for severe)

___Angina-rest ___Angina-exertion ___Dyspnea
___Significant arthritis ___Paralysis ___Dysphagia
___Aphasia ___Contracture(s)
___Mental Disorder(s) ___Allergies
___Other:

3. Professional and Technical Care Needs (check all that apply – PT, ST and OT are only provided by Physican Order and through Home Health or Outpatient):

___Physical therapy ___Speech therapy ___Occupational therapy
___ Nebulizers ___Self inhalers ___Intermittent oxygen
___Continuous oxygen

4. Medication administration and storing of medication so that they are inaccessible to other residents:

___Self ___Welty Home Staff
Comments/Other:

5. Services required by this individual can be met in an assisted living facility:

___Yes ___No
Comments/explanation:

6. Resident is in need of direct sleep time supervision:

___Yes ___No
Comments/explanation:

7. **Diet order:** Welty Home provides **ONLY** the following diets.
___Regular ___Limited concentrated sweets
___No fried foods ___No added salt

8. **Activity restrictions:** (Describe)

9. **Mental Health:** Has the individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness?
___Yes ___No

If yes: Agency: Address:
Admission date: Discharge date:

10. **Medication(s),** including over the counter medications and treatment orders:

_____ _____
_____ _____
_____ _____
_____ _____

11. **Tuberculosis screening:** Does individual have any of the following symptoms?

	NO	YES*			NO	YES*
Persistent cough >3 weeks				**Loss of appetite,**		
Bloody sputum				**Unexplained weight loss**		
Night sweats				**Unexplained fever**		

*IF YES to any of these, a PPD or Chest X-Ray must be completed.

	NO	YES: *Note Date & Results*
PPD or Chest X-Ray Indicated?		

12. **Functional level:** Indicate functional level in left column using the following determining factors: (occasional—less than three times a week; frequently—more than three times a week)

Item	Level 1	Level 2	Level 3	Level 4
___Mental Status	Clear	Occas. Confused	Confused	Comatose
___Short term memory	Good	Occas. Lapse	Poor	
___Eating	Self	With assist.	Total care	Tube feed
___Bathing	Self	With assist.	Total care	
___Dressing	Self	With assist.	Total care	
___Cont/urine	Continent	Occas. Incontinent	Incontinent	Catheter
___Cont/bowel	Continent	Occas. Incontinent	Incontinent	Colostomy

	Level 1	Level 2	Level 3
___Noisy	Never	Occasionally	Frequently
___Combative	Never	Occasionally	Frequently
___Withdrawn	Never	Occasionally	Frequently
___Wanders	Never	Occasionally	Frequently
___Suicidal	Never	Occasionally	Frequently
___Mobility	Ambulatory	Cane/Walker	Wheelchair mobile
___Sight	Not impaired	Impaired	Blind
___Hearing	Not impaired	Impaired	Deaf
___Speech	Not impaired	Impaired	Aphasic
___Respiratory	Not impaired	Impaired	Continuous Oxygen

13. Clinical and psychosocial data: please check any of the following behaviors that the individual has exhibited in the last two years:

___Combative
___Withdrawn/depressed
___Hallucinates
___Delusional
___Disoriented
___Bizarre behavior
___Dangerous to self/others
___Seriously impaired judgment
___Suicidal thoughts, ideation, gestures
___Unable to communicate basic needs
___Talks about his/her worthlessness
___Unable to understand simple commands
___Experience difficulty learning new skills
___Displays inappropriate social behaviors
___Demonstrates severe maladaptive behaviors
___Specialized training needs

Does the individual have Alzheimer's, multi-infarct, senile dementia or related conditions:
____Yes ___No If yes, specify:

15. Diagnoses:
Primary:

Secondary:

Other medical conditions requiring services:

To the best of my knowledge, this individual's medical needs and related needs are essentially as indicated above:

Physician's name:_____ **Signature:**_____

Address:_____

Phone number:_____ **Date:**_____