

**CHARLOTTE HALL VETERANS HOME
ADMISSIONS APPLICATION (PART 2)**

29449 Charlotte Hall Rd
Charlotte Hall, MD 20622
(301) 884-8171

We have found that the more details we know about our residents when they are admitted, the better care we can give. Often, the details of a person's past life turn out to be important factors in his/her happiness here at our facility. The information you provide us here is confidential and used only for professional purposes. Sending these completed forms in advance will offer us the opportunity to better know your loved one when they are admitted. If you are uncertain about any of these questions, please feel free to skip them or call and ask for assistance.

Resident's Name: _____

Name Resident prefers to be called: _____

CURRENT SITUATION

A. Living Arrangements:

- Living alone (apartment or own home)
- Living with family/friend, if so who: _____
- Hospital, if so specify: _____
- Nursing home/Assisted Living, if so specify: _____

Describe what has changed in the present situation that requires the resident to come to Charlotte Hall

Has the resident been told about coming to Charlotte Hall? What was the reaction?

B. Physical/Medical Information:

1. **Ambulation** : Please check any that apply

Walking Normal Slow but steady Unsteady Not walking Cane
 Crutches Walker Leg braces Artificial limb

Wheelchair Propels self Others push Motorized

Bedridden Yes No

Describe any recent history of falling and any injuries related to falls: _____

2. Care of Self

	Alone	Needs Help	Unable
Dressing self			
Washing hands and face			
Showering/Bathing			
Getting in and out of bed			
Getting in and out of chair			
Washing/Combing hair			
Trimming finger/toe nails			
Shaving			
Brushing teeth/dentures			
Using toilet			

Bowel Control: Normal Occasional loss of control Unable to control
 Enemas/Suppositories

Frequency: _____ Time of Day: _____

Bladder Control: Normal Occasional loss of control Unable to control
 Catheter

Frequency: _____ Time of Day: _____

3. Impairments or Problems

Speech: Clear Unclear Nonverbal

If impaired how does resident communicate: _____

Vision: Clear Glasses Poor Blind

Hearing: Clear Hearing Aid Poor Deaf

Teeth: Yes Dentures upper lower None

Skin condition: _____

Wounds, describe: _____

Feet /legs condition: _____

Any amputations?_ _____

Any other physical impairments/problems? _____

4. Medication

Current medications: _____

Any allergies or sensitivities to medicines: _____

Any major illnesses: _____

5. Psychiatric

Any history of mental illness : _____

Has the resident ever seen a psychiatrist? If so, for what reason: _____

(provide psychiatric evaluations and list history of hospitalizations, locations, treatments, etc separately)

Any history of drug or alcohol abuse: _____ If yes, how long ago: _____
Did you complete a structured program? _____ If so, when and where: _____

Does the resident have any pending criminal charges (including DUI/DWI)? _____

6. Preferences

A. Eating

Foods resident dislikes: _____

Foods resident is allergic: _____

Food that causes indigestion: _____

Appetite: Normal Poor Overeats

Eating: Feeds self Needs help Tube fed

B. Sleeping

Usual bedtime _____PM Usually awakens _____AM

Sleeping habits: Normal Restless Wanders at night
 Daytime dozing Needs side rails

C. Smoking

Does the resident smoke? _____ If so, amount, brand preference, and who will supply:

C. Personality

1. Check any of the following which describe resident's present condition. Star (*) any items that have developed recently.

- | | |
|--|---|
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Wants to get well |
| <input type="checkbox"/> Sociable | <input type="checkbox"/> Noisy |
| <input type="checkbox"/> Cheerful | <input type="checkbox"/> Silent |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Reserved |
| <input type="checkbox"/> Too Independent | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Mentally alert | <input type="checkbox"/> Temper outbursts |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Chronic complaining | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Slightly forgetful | <input type="checkbox"/> Often angry |
| <input type="checkbox"/> Very forgetful | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Prefers groups | <input type="checkbox"/> Worries |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Has spoke of suicide |
| <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Has attempted suicide |
| <input type="checkbox"/> Sensitive | <input type="checkbox"/> Paranoid |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Sees things that aren't there |
| <input type="checkbox"/> Excessive laughter | <input type="checkbox"/> Hears things that others don't |

2. How does the resident accept reality: _____

3. Anything specific that upsets resident? Suggestions for handling _____

4. Who does the resident trust the most? _____

5. Who does the resident trust the least? _____

6. Can the resident manage pocket money? If so, how much _____

7. Are there financial problems the resident is worried about? If so please explain : _____

8. Any interests/hobbies : _____

9. In the event the resident improves and is able to be discharged, the tentative plan would be:

- Own home
- Home of family member, Name _____
- Assisted living
- No plan

Any additional information or comments : _____

Born and raised where: _____

Native language: _____ Speaks native language frequently? _____

Names, ages, and location of siblings (if deceased please note when)

Please describe resident's childhood/adulthood: _____

Any travels: _____

How far did the resident go in school: _____

Any trade school or on the job training: _____

What was the resident's main occupation (s): _____

Did the resident plan for retirement: _____

Date of retirement: _____ Voluntary Involuntary

Any work after retirement: _____

Marriage

Date of marriage: _____ Spouse's name: _____

Is spouse still living? Yes No If deceased, when and what was resident's reaction:

Describe any important characteristics of the marriage: _____

Number of children, location, and relationship with resident: _____

Grandchildren: Yes No If yes how many? _____

Thank you for completing this application. We look forward to you and your loved ones joining our facility family.

Person completing application: _____