

**Southington Care Center
Short Term Rehab Application**

Vital Statistics

Name _____ Telephone _____

Address _____ Town _____ State _____ Zip _____ - _____

Date of Birth _____ U.S. Citizen Yes No

Marital Status _____ Religion _____ Veteran Yes No Male Female

Medical Information

Date of Admission to Hospital (Surgery Date) _____

Reason for Admission to Hospital _____

Name of Hospital _____

Surgeon _____ Primary Care Physician _____

Past Medical History _____

Allergies _____

Current Medications _____

Diet _____ HT _____ WT _____

Mental Status:

Alert Oriented Confused Disoriented Forgetful

Vague Non-responsive Depressed

Behavior Patterns:

Cooperative Wanders Paces Combative Verbally Abusive

Resistive to Care Easily Agitated Other _____

Continence:

Continent Incontinent

Foley Catheter Suprapubic Catheter Texas Catheter (External Device)

St. Catheter Colostomy Ileo Conduit

Oxygen/Liters _____

Pace Maker Yes No Date Inserted _____

Prosthesis (Type) _____

History of Psychiatric Problems or Disorders? (Include Details and Dates of Hospitalization) _____

History of Alcohol or Substance Use? If Yes, Describe _____

Smoker Yes No

Other Physician(s) _____

Advance Directives Yes No

If Yes, Please indicate: POA DPOA HCA Living Will Organ Donor Conservator

During the last 60 days, has there been a stay in a hospital or nursing facility? _____ If so, please indicate where and when stay took place. _____

Have Home Care Services been used in the past? _____

If so, please indicate which agency _____

Personal Contact/Insurance Information

Primary Contact

Name _____ Relationship _____

Address _____ Home Phone _____

Town _____ Zip Code _____ Work Phone _____ Cell Phone _____

Secondary Contact

Name _____ Relationship _____

Address _____ Home Phone _____

Town _____ Zip Code _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Medicare Number _____

Health Insurance Plan _____ Policy # _____

Medicare Supplement _____ Policy # _____

Medicaid Number (Title 19) _____ Pending? Yes No

Medicaid Caseworker's Name _____ Phone _____

Copies of cards enclosed (back and front) Yes No

(Name and information of person completing application)

Name _____ Phone No. (home) _____

Address _____ Phone No. (work) _____

Town _____ State _____ Zip Code _____

Relationship _____

Signature of person completing application