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

Mechanical Aids

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

Southington Care Center is a Non Smoking Facility.

Miscellaneous Information

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______________________________

Funeral Home Preference: ______________________________

Have arrangements been made? ______________________ Prepaid? ______________________

Personal/Financial 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 ____________

Financial Disclosure: (All information supplied will remain confidential. Application cannot be processed without this information.)

Social Security # ________________ Medicare# ________________

Medicaid Number (Title 19) ________________ Pending? ❑ Yes ❑ No

Medicaid Caseworker's Name ______________________ Phone ______________________

Managed Medicare, Commercial Insurance or Medicare Supplement ______________________

Policy No. ________________ 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 _________

Relationship ______________________________ ______________________________

Signature of person completing application