

# FALLON MEDICAL COMPLEX

PO Box 820 ♦ Baker, Montana 59313-0820

## RESIDENT PROFILE PRE-ADMISSION/ADMISSION INFORMATION SHEET

This Facility is owned and operated by Fallon Medical Complex, INC.

This Facility accepts residents of all backgrounds who are in need of 24 hour nursing care. The facility has a combination of 40 beds – inpatient, skilled Medicare and intermediate swing bed and nursing home beds.

This Facility is staffed with healthcare professionals, managers and staff who strive constantly to make the facility a place where the residents are treated with dignity and respect.

Room rates will be discussed with the prospective resident and his/her responsible party by the Interdisciplinary Team, which consists of nursing, social services, activities, dietary, physical therapy, and business office personnel.

Admission procedure is based on the following:

- The Facility must have a current Application for Admission completed by the perspective resident and/or the responsible party.
- Once the above information has been received, the application will be reviewed for admission by the Interdisciplinary Team. **Upon acceptance and prior to admission**, the perspective resident must be seen by a medical provider for a nursing home admission physical.  
When a bed becomes available for an approved resident, the resident/responsible party will be notified and admission arrangements will be made at that time. (All residents will be admitted at a pre-arranged time during regular business hours).
- **The Interdisciplinary Team requests that the potential resident/responsible party bring copies of any legal documents, which include Financial Durable Power of Attorney, Medical Durable Power of Attorney, Guardianship, Advance Directives, Living Wills, etc.**
- If you have any questions, please feel free to contact Mary Mangold, the Social Services Manager at 406-778-5107, or (406) 778-3331 ext. 203, Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m.

**\* PLEASE NOTE THAT COMPLETION OF THE PRE-ADMISSION FORM DOES NOT GUARANTEE PLACEMENT AT THIS FACILITY.**

Remember we also need an accepting physician here in Baker: Dr. Espeland or Dr. Trivisonno

Current room rates – Please contact Social Services

**When accepted to Fallon Medical Complex Nursing Home please bring the following to your clinic appointment before admission:**

1. Please bring all medications, in their original bottles, that you are currently taking. This includes herbal supplements, vitamins, eye drops and any over the counter medication. This is so you can review these with your provider to ensure you or your loved one receives the correct medications here at FMC.
2. Please be sure to write a list of all questions or concerns you have about long term placement, pain, skin issues, etc. so the provider can answer or prescribe something to make the transition easier for you and your loved one.
3. If your loved one is having problem chewing or swallowing be sure to let your provider know so he/she can order the correct diet.
4. If there any special treatments (i.e. corn pads) or care that you are providing at home that you would like to see continued here at Fallon Medical Complex please be sure to let your provider know.
5. Thank you for your help and cooperation in making sure we provide the best care for your loved one!

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## APPLICANT/RESIDENT PRE ADMISSION PROFILE

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PLEASE COMPLETE ALL SECTIONS

Applicant/Resident Information:				
Name:	Date of Birth:	Age:	Sex:	
Address:	City:	State:	Zip:	Phone: ( )
Religion:	Marital Status: S M W D	Birth Place:		
Social Security Number:	Medicare Number:	Medicaid Number:		
Health Insurance:	Policy #:	Group #:		
Maiden name:	Mothers maiden name:	Military: <input type="radio"/> Yes <input type="radio"/> No Branch:		
Attending Physician in Baker:	Physician Phone Number:			

Hospitalization:		
Have you been hospitalized in the last 12 months? <input type="radio"/> Yes <input type="radio"/> No If <b>Yes</b> , please complete the following information:		
Acute Hospital Name: (Most Recent)	Admit Date:	Discharge Date:
Skilled Nursing Facility Name: (Most Recent)	Admit Date:	Discharge Date:
Applicant/Resident is currently residing at:	Admit Date:	

In Case of Emergency, Notify:			
Name:	Relationship:		
Home Phone: ( )	Business Phone: ( )		
Address:	City:	State:	Zip:
Name:	Relationship:		
Home Phone: ( )	Business Phone: ( )		
Address:	City:	State:	Zip:

Responsible Party:			
Name:	Relationship:		
Home Phone: ( )	Business Phone: ( )		
Address:	City:	State:	Zip:
Send Statement/Bill To: (Name, Address, Phone)			

Legal Documentation
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Do you have the following documents? (Beneficial for everyone concerned, please bring copy to admission conference)			
<input type="checkbox"/> Durable Power of Attorney	<input type="checkbox"/> Durable Medical Power of Attorney	<input type="checkbox"/> Living Will	<input type="checkbox"/> Guardianship
<input type="checkbox"/> Conservator	<input type="checkbox"/> Do Not Resuscitate	<input type="checkbox"/> Medical Advance Directives	

## FALLON MEDICAL COMPLEX - NURSING HOME

PO Box 820 ♦ Baker, Montana 59313-0820

### APPLICANT/RESIDENT SOCIAL EVALUATION

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<b>Applicant/Resident Information:</b>	
Applicant/Resident Likes To Be Called (Nickname)	
Current Living Arrangements: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Other:	
Do You Live Alone? <input type="checkbox"/> Yes <input type="checkbox"/> No    Explain:	
Previous Occupation:	Education:

<b>Family Members:</b>	
Spouse Name:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased, date:
Children: (If more, list on back of form)	
Name:	Phone: (    )
Name:	Phone: (    )
Name:	Phone: (    )
Name:	Phone: (    )
Interested Others:	
Name:	Phone: (    )
Name:	Phone: (    )
Who will visit?	How often?

<b>Special Interests:</b>
Hobbies:
Club Memberships:
Recreational Activities:
Other Interests:

<b>Psychosocial:</b>
Has individual been informed of possible admission to the nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No
How do you feel about your present situation?

How does your family feel about your present situation?
Do you have any financial concerns?
Have you had any recent losses? <input type="radio"/> No <input type="radio"/> Yes Please Explain:
Handicaps? <input type="radio"/> No <input type="radio"/> Yes If yes, how does this make you feel?
Completed by: _____ Relationship _____ Date: _____

**FALLON MEDICAL COMPLEX - NURSING HOME**  
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**APPLICANT/RESIDENT PHYSICAL HEALTH HISTORY**

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<b>Current Physical Health Problems:</b>			
<input type="radio"/> Alzheimer's	<input type="radio"/> Diabetes	<input type="radio"/> Hypertension	<input type="radio"/> Pain
<input type="radio"/> Dementia	<input type="radio"/> Heart Disease	<input type="radio"/> Obesity	<input type="radio"/> Contractures
<input type="radio"/> Hearing Impaired	<input type="radio"/> Limited Vision	<input type="radio"/> Seizure Disorder	<input type="radio"/> Paralysis
<input type="radio"/> Bowel Incontinence	<input type="radio"/> Respiratory	<input type="radio"/> Cancer	<input type="radio"/> Speech Impaired
<input type="radio"/> Parkinson's	<input type="radio"/> Blind	<input type="radio"/> Fracture	<input type="radio"/> CVA/Stroke
<input type="radio"/> Arthritis	<input type="radio"/> Feeding Tube	<input type="radio"/> Urine Incontinence	<input type="radio"/> Gastrointestinal Disorder
<input type="radio"/> Decubitus Ulcer	<input type="radio"/> Catheter Use	<input type="radio"/> Infections (UTI, Respiratory, etc.)	
<input type="radio"/> Hallucinations	<input type="radio"/> Smoker	<input type="radio"/> Alcohol Consumption	

<b>Which of the following best describes the applicant's / resident's ability to walk:</b>	
<input type="radio"/> Fully independent	<input type="radio"/> Uses wheelchair independently
<input type="radio"/> Unsteady	<input type="radio"/> Uses wheelchair with assistance
<input type="radio"/> Uses cane or walker independently	<input type="radio"/> Uses gait belt
<input type="radio"/> Uses cane or walker with assistance	<input type="radio"/> Total assistance with transfers
Falls History: <input type="radio"/> Yes <input type="radio"/> No Most Recent Fall Date: _____	How many falls in last month? _____
Comments:	

<b>Which of the following best describes the applicant's / resident's behavioral status:</b>		
<input type="radio"/> Knows people	<input type="radio"/> Able to verbalize feelings	<input type="radio"/> Crying
<input type="radio"/> Knows where they are	<input type="radio"/> Confused	<input type="radio"/> Anxious
<input type="radio"/> Knows day of week, season etc.	<input type="radio"/> Forgetful	<input type="radio"/> Nervous
<input type="radio"/> Able to make eye contact	<input type="radio"/> Noisy	<input type="radio"/> History of psychiatric treatment

<input type="checkbox"/> Opens eyes but does not respond	<input type="checkbox"/> Aggression	<input type="checkbox"/> Verbal	<input type="checkbox"/> Physical	<input type="checkbox"/> Yells out
<input type="checkbox"/> Unresponsive to stimuli	<input type="checkbox"/> Angry	<input type="checkbox"/> Wanders		
<input type="checkbox"/> Sexually inappropriate behavior	<input type="checkbox"/> Agitated	<input type="checkbox"/> Depression		

Comments:

**Socialization/Activity Interests:**

<input type="checkbox"/> Prefers to be Alone	<input type="checkbox"/> Enjoys Being Around Others	<input type="checkbox"/> Occasionally Enjoys Being Around Others
Usual Bedtime:	Naps <input type="checkbox"/> Yes <input type="checkbox"/> No	Time of Day:
Bath: <input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		

**Mortuary (required):**

Have pre-arrangements been made? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mortuary Name:		Phone: (     )	
Address:	City:	State:	Zip:

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**APPLICANT/RESIDENT PHYSICAL HEALTH HISTORY**

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**Personal Care Activities:**

	Fully Independent	Needs Supervision	Needs Some Physical Assist	Needs Much Physical Assist	Needs Total Care
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Nutritional Status:**

Special Diet:			
Adaptive Equipment:	<input type="checkbox"/> "Raised Lip" Dishes	<input type="checkbox"/> Weighted Utensils	<input type="checkbox"/> Other:

**Oral Care:**

<input type="checkbox"/> Own Teeth	<input type="checkbox"/> Full Dentures	<input type="checkbox"/> Partial Dentures	<input type="checkbox"/> Upper Dentures	<input type="checkbox"/> Lower Dentures
<input type="checkbox"/> Missing Teeth	<input type="checkbox"/> Dental Cavities	Last Dental Exam Date:		
Name of Dentist:		Address/Phone:		

**Vision:**

<input type="checkbox"/> Normal Vision	<input type="checkbox"/> Wears Glasses	<input type="checkbox"/> Limited (Large Print)	<input type="checkbox"/> Legally Blind	Last Exam:
Name of Eye Doctor:		Address/Phone:		





