Crouse Community Center

101 South Street

Morrisville, NY 13408

APPLICATION FOR ADMISSION - MEDICAL

(Note: To Be Completed By Physician)

Name of Applicant: _____ Date of Birth: _____

Address: _____

Sex: _____

Active Diagnoses: _____

Medications	Dose	Route	Frequency	Reason For Use

Past Medical History: _____

Past Surgical Procedures / Dates: _____

Recent Lab Work: _____

Recent X-Rays: _____

Allergies: _____

Pneumovax: Yes / No Date: _____ Flu Vaccine: Yes / No Date: _____

TB Skin Test: Yes / No Date: _____ Result: _____

Tetanus Immune Status: _____

Current Treatments: _____

Name of Applicant: _____ ~~Application for Admission-Medical Continued~~

Pressure Ulcers: Yes / No State & Location: _____

Other Skin Conditions: _____

History of Alcoholism: _____

History of Drug Addiction: _____

History of OR Current Communicable Disease: _____

Advanced Directives: ____ DNR ____ Health Care Proxy ____ Power of Attorney ____ Living Will

List Specialists Seen By Applicant:

Dentist: _____ Podiatrist: _____

Audiologist: _____ Ophthalmologist: _____

Psychiatrist: _____ Other: _____

Special Diet or Consistency: Yes / No Specify: _____ Feeds Self: Yes / No

Hearing: ____ WNL / Impaired / Severe Hearing Aid: ____ Yes / No

Vision: ____ WNL / Impaired / Severe Glasses: ____ Yes / No

Speech: ____ WNL / Impaired / Severe

Mental Status: (Check All That Apply) ____ Oriented ____ Cooperative ____ Wanders

Confusion: ____ Occasionally ____ Always ____ Noisy ____ Assaultive ____ Agitated

Other: _____

Dementia Screen Done: Yes / No

History of Psychiatric Problems / Current Status: _____

Mobility: ____ Ambulatory ____ With / Without Assist

Devices Used: ____ Cane ____ Walker ____ W/C ____ Other

Incontinence: Bladder: ____ Always ____ Occasionally ____ At Night

Bowels: ____ Always ____ Occasionally ____ At Night

Continent: ____ Foley Catheter / Size / Reason: _____

Colostomy: _____

Recommendations for Routine Care: _____

Do You Recommend Nursing Facility Placement? Yes / No

Physician's Signature: _____ Date: _____

Physician's Address: _____

Note: Please Include Copies of Most Recent History and Physical, Any Recent Lab Work and Any Operative Reports…. Without the Above Information Admission May be Denied

State and Federal Laws Prohibit Discrimination Based on Race, Creed, Color, National Origin, Sex or Sponsor

CCC/3-06 sdj