Charlevoix County Medical Care Facility
1728 South Peninsula Rd. East Jordan, MI 49727
Phone: (231) 308-9225 Fax: (231) 536-0393
Email: achristie@grandvue.org

Please complete this application and return to Grandvue Medical Care Facility at the address shown. If you need assistance, please feel free to contact the Admissions Coordinator at 231-308-9225. I look forward to working with you.

ADMISSION APPLICATION

APPLICANT INFORMATION		
Name:		Date of Birth:
Full Legal Name:		
Home Address:		
Mailing Address:		
Telephone #:	Alt. Phone #:	
Email Address:		
County of Residence:		

INSURANCE & LEGAL INFORMATION: ***WE MUST RECEIVE COPIES OF ALL CARDS WITH THIS APPLICATION***			
Social Security #:	Medicare #: A B		Medicaid #:
Other Insurance:	Supplemental:		
Vision:	Dental:		Prescription:
Long Term Care Insurance:			
Is this covered by Workman's Comp?		If yes, dates:	
Is this covered by Auto Insurance?	If yes, dates:		Company
Will you be applying for Medicaid?			

Does the applicant have a:

Legal Guardian

Conservator

Healthcare Power of Attorney

Financial Power of Attorney

None of the above

THIS APPLICATION IS VALID FOR 45 DAYS UPON RECEIPT

RESPONSIBLE PARTY		
Person Responsible for assisting with <u>healthcare</u> matters of applicant		
Name:		Relationship:
Address:		
Telephone #:	Alt. Phone #:	
Email Address:		
Preferred Method of Contact: Cell Phone Email		
Person Responsible for assisting with <u>financial</u> matters of applicant		
Name:		Relationship:
Address:		
Telephone #:	Alt. Phone #:	
Email Address:		
Preferred Method of Contact: Cell Phone Email		

<u>IMPORTANT NOTICE</u>

****

INCLUDE COPIES OF GUARDIANSHIP, POWERS OF ATTORNEY, ADVANCE DIRECTIVES AND MEDICAL/INSURANCE CARDS FOR THE APPLICANT

****

_____ _____

Print Name **Date**

_____

Signature

Please return completed Admission Application to:
Grandvue Medical Care Facility / Admissions
1728 South Peninsula Rd. East Jordan, MI 49727
Phone: (231) 536-2286, ext. 3025 Fax: (231) 536-0393
Email: admissions@grandvue.org

THIS APPLICATION IS VALID FOR 45 DAYS UPON RECEIPT

GRANDVUE
Charlevoix County Medical Care Facility

"RESIDENT HISTORY"

In order to provide person centered care for each resident, it is helpful to know more about their background, routine and preferences. This information will be especially helpful in developing a plan of care. Thank you.

Resident Name: _____Place of birth (City):_____ State: _____

D.O.B.: _____ Maiden Name: _____

Parents' Names: Mother _____Father _____

Age/ Cause of Death_____ Age/Cause of Death _____

Brothers (names/ages/causes of death if deceased) _____

_____

Sisters (names/ages/causes of death if deceased) _____

_____

Ethnic Background of Family: _____

Schooling of resident (place/highest grade/favorites, etc.) _____

_____

Spouse's Name: _____ Date/Place of Marriage: _____

Age/Cause of Death/Date of Death _____

Prior Marriage(s) Date: _____ Name: _____

Children (names, where they live): _____

_____

Resident's former occupation(s): _____

Last Employer: _____ How many years: _____

Other Work History: _____

Year Retired: _____Shift Worked: _____

What does the resident remember most about his/her job? _____

_____

Veteran or spouse of veteran? _____ Branch of Service: _____ Years: _____

Active in Veteran Organizations: _____

Registered Voter? Yes _____ No _____ If yes, where? _____ If no, would resident like to be registered? Yes _____ No _____

Activity Interests:

Please place an "X" if interested. Place a "P" if a past interest only.

Physical Activities:
( ) Baseball
( ) Basketball
( ) Biking
( ) Boating
( ) Bowling
( ) Camping
( ) Dancing
( ) Fishing
( ) Football
( ) Golfing
( ) Hunting
( ) Running
( ) Sports Fan _____
( ) Swimming
( ) Tennis
( ) Other _____

Other:
( ) Bird Watching
( ) Clubs _____
( ) Dining Out
( ) Driving
( ) Pets _____
( ) People Watching
( ) Shopping
( ) Traveling
( ) Volunteer
( ) Computer

Music/Television:
( ) Music Preference _____
( ) TV Preference _____
( ) Radio Preference _____

Reading:
( ) Books _____
( )Magazines_____
( ) Book Tapes _____
( ) Newspaper _____
( ) Religious _____
( ) Prefers Large Print

Arts/Crafts/Hobbies:
( ) Ceramics
( ) Crafts
( ) Drawing
( ) Handiwork _____
( ) Woodworking _____
( ) Collections _____
( ) Sewing _____
( ) Other _____

Games:
( ) Cards _____
( ) Video Games
( ) Bingo
( ) Other

Domestic:
( ) Baking _____
( ) Cooking _____
( ) Gardening _____

Likes groups: Yes _____ No _____ Likes doing things alone: Yes _____ No _____

Church Attended: _____Attendance History _____ Religion of Choice _____

Are there any special religious symbols that are meaningful? (rosary, hymns, bible, crucifix, etc.)
_____

Are there any religious instructions you want us to know about? (last rites, anointing of the sick, always read the Bible in the morning, uses devotional materials daily, etc.)

_____

_____

Would resident desire contact with a priest/minister? _____

History of Coping:

Has the resident ever received mental health services: outpatient counseling, inpatient mental health unit, etc? _____ If yes, explain: _____

_____

Has resident ever been diagnosed with depression or anxiety: Yes _____ No _____
If yes, please explain:
_____

Has resident ever been diagnosed with any other mental health diagnosis? Yes _____ No _____
If yes, please explain:
_____

Does the resident now or has he/she ever in the past taken any type of medication for any of the above mental health conditions? (antidepressants, anti-anxiety, anti-psychotics): Yes ___ No ___
If yes, please list medications and date: _____

_____

Has resident ever attempted or threatened suicide? Yes _____ No _____ If yes, please explain:

_____

_____

Does resident now or has he/she ever in the past used alcohol or tobacco? Yes _____ No _____
If yes, please explain, listing amounts, frequency, type: _____

_____

_____

Has this resident ever experienced an addiction to any substance (alcohol, drugs, tobacco, etc.):
Yes _____ No _____ If yes, please explain: _____

_____

How does this person usually cope during difficult times? (crying, yelling, withdrawal, prayer, seek out family members, etc.) _____

_____

Losses in Life:

Recent: _____Past: _____

How has resident dealt with them: _____

Does this person have any history of being abused (physically, emotionally, or sexually) that you are aware of? Yes _____ No _____
If yes, please explain: _____

_____

Has this resident had a history of abusing themselves? Yes _____ No _____ If yes, please explain:

_____

_____

_____

Has this resident had a history of abusing others? Yes _____ No _____ If yes, please explain:

_____

_____

_____

What are some accomplishments that he/she is especially proud of? _____

_____

_____

What are some disappointments that he/she wishes would or could have turned out differently?

_____

_____

_____

History of Trauma:

Has your loved one experienced traumatic events (combat in war; death of an infant, child, grandchild, etc.; unexpected death of loved one; auto accidents; fire; etc.) Yes _____ No _____

If yes, what _____

If yes, when _____

Does your loved one talk about traumatic events? Yes _____ No _____

Is there a particular time of year or season that is more difficult for your loved one? Yes __ No __

If yes, when _____

Behavior Pattern:

Any history of physical aggression (hitting, biting, kicking, slapping, pushing, etc.): Yes __No ___

If yes, describe _____
_____

Any known factors that may contribute to or provoke above behavioral issues? Yes ___No ___

If yes, what? _____

Any particular time of day that is more difficult? Yes _____ No _____

If yes, explain _____

Any history of wandering? Yes _____ No _____ If yes, where? _____

If yes, when? _____

Any history of verbal aggression (making threats, yelling at, swearing at, etc.)? Yes ___ No ___

If yes, explain _____

_____

How have you/others handled these behaviors? _____

_____

_____

_____

_____

What worked? _____

_____

_____

What did not work? _____

_____

_____

WHAT ELSE WOULD YOU LIKE TO TELL US ABOUT YOUR LOVED ONE THAT WOULD HELP US BETTER CARE FOR HIS OR HER NEEDS? _____

_____
_____

What family issues (past & present) should we be aware of? _____ If yes, please explain:

_____

_____

_____

Does anyone in the family need additional support from community resources that we could help arrange? (spouse remaining in the home, filing for Medicaid insurance, transportation to visit, stress, own declining health, etc.) _____ If yes, please explain: _____
_____
_____

How are you and the rest of the family feeling about placement of your loved one?

_____

_____

_____

_____

How can we help you during this difficult time (communication, services, etc.):

_____

_____

_____

What will be the most difficult change for your loved one? _____

_____

_____

Daily Routine:

Usual rising time: _____

Breakfast foods: _____

Lunch foods: _____

Supper foods _____

Food dislikes _____

Any chewing or swallowing problems? Yes _____ No _____
If yes, please describe: _____

Does your loved one need assistance with eating? Yes _____ No _____
If yes, describe (cueing, fewer plates, finger foods, physical assistance)
_____

Has your loved one had any difficulty handling cups, plates or silverware? Yes____ No_____
If yes, please describe (spilling liquids, dropping food off silverware, etc.)
_____

Recent weight change (gain or loss): Yes _____ No _____
If yes, how much _____

Does your loved one prefer to eat alone or with someone? Alone _____ With someone _____

Usual bed time _____

Describe bedtime routine

_____

_____

Special bedtime preferences (please circle): raised edge mattress body pillow TV/Radio Fan

Does your loved one sleep alone or with someone? Alone _____ With someone _____
If with someone, who? _____

Does your loved one get up at night to use the bathroom? Yes _____ No _____ How often? _____

_____

Does your loved one use a bedside commode? Yes _____ No _____

Does your loved one have a history of constipation or loose stools? Yes _____ No _____
If yes, describe _____

If yes, what helps? _____

Does your loved one have a history of laxative use? Yes _____ No _____

Does your loved one get up at night for other reasons? Yes _____ No _____

If yes, what reason and how often? _____

Does he/she usually nap? Yes _____ No _____ If yes, when and where _____

_____

Please describe a normal day for your loved one (meal times, activities during the day, stays inside/goes outside, etc.)

_____

_____

_____

Does your loved one usually have frequent contact with family? Yes _____ No _____

Does your loved one prefer a shower _____ or bath _____ and how often _____

Favorite pet _____ Name of pet _____

Does your loved one start activities on his/her own? Yes _____ No _____ If no, how do you get your loved one involved in activities?

_____

_____

Has there been a recent change in daily routine? Yes _____ No _____ If so, please explain:

_____

_____

_____

Would your loved one like a change in activity participation? Yes _____ No _____

Does your loved one have difficulty hearing? Yes _____ No _____

Does your loved one have hearing aids? Yes _____ No _____ If yes, does your loved one wear them? Yes _____ No _____

Last hearing appointment: _____ Name of doctor: _____

Does your loved one have difficulty seeing? Yes _____ No _____

Does your loved one have prescription eyeglasses? Yes _____ No _____ If yes, does your loved one wear them? Yes _____ No _____

Eye doctor's name:_____ Date of last appointment: _____

Does your love one use any other adaptive equipment (magnifying glass, communication board, walker, cane, wheelchair, etc.)? Yes _____ No _____ If yes, when does your loved one use it?

_____

_____

Does your loved one have memory problems? Yes _____ No _____ If yes, please describe:

_____

_____

History of falls: Yes _____ No _____
If yes, explain: _____

Any emergency room visits in the last 90 days? Yes _____ No _____
If yes, explain: _____

Any hospital admissions in the last 90 days? Yes _____ No _____
If yes, explain: _____

Any history of physical discomfort or pain in any certain area? Yes _____ No _____
If yes, explain: _____

What helps: _____

What makes it worse: _____

Medicine used: _____

Non medicine techniques used (hot/cold pack, positioning, stretching, etc.):
_____

Dominant hand: Right _____ Left _____

How did your loved one take medications at home?
Time of day: _____

Whole _____ Crushed _____

Were medications mixed with anything? _____

Do you/your loved one want medications given the same way they were taken at home?
Yes _____ No _____ If not, then how? _____

Do you/your loved one wish to be awakened for medications? Yes _____ No _____

Anything else you would like us to know about your medications? _____
_____

Thank you for taking the time to complete this history. With your help we will better meet the needs of your loved one. Please feel free to talk with us at any time about any of these questions in more detail.

_____ _____
Signature of Person Completing Date

Phone number to be reached if further information is needed: _____