Southern Harbor Eldercare Services
12 Pulpit Harbor Road
North Haven, Maine 04853
207-867-2345

Southern Harbor House
Application and Pre-Admission Form

Applicant's Name: _____/ /_____

Date of Birth: _____Male/Female: _____ Marital Status_____

Address: _____

Religion: _____ Place of Birth: _____

Height: _____ Weight: _____

Social Security Number: _____

Ambulatory: _____ (Yes/No) Lived Alone: _____ (Yes/No)

Highest Level of Education: _____ Occupation: _____

Admitted From: _____Location: _____

If admitted from home, date of most recent hospitalization: _____ dd/m m /yyyy

Family / Responsible Person Contacts:

- Please indicate if the person listed as a contact has Power of Attorney or other special legal relationship to the patient. Please attach copy of Power of Attorney and Advance Directives.

Primary Contact:

Name: _____ ___ Relationship: _____

Address: _____

Phone Number Home: _____Work: _____

Cellular: _____

Secondary Contact:

Name: _____ Relationship: _____

Address: _____

Phone Number Home: _____ Work: _____

Cellular: _____

Additional Contact:

Name: _____ Relationship: _____

Address: _____

Phone Number Home: _____ Work: _____

Cellular: _____

Advance Directives: ____Living W ill____POA_____Durable POA____Healthcare POA

For application to be valid, each checked item must include a copy of the corresponding document as an attachment.

Financial arrangements: _____Yes_____No. If no, invoices will be sent directly to you. If yes, to whom would bill be directed? (Name, Address, Phone number)

Monthly Income of Applicant_____SocialSecurity_____Other_____ MaineCare Applied for on ___/___/___ (or Estimated Date MaineCare applied for___/___/___)

Copies of all checking and savings account statements for past three months must be attached to this application.

Facility Use Only

Admission Date: _____ Coming by: _____ Room Assigned:_____

Assessment (To be done by Facility or Primary Care Provider)

Applicant's Name: _____ Age: _____ Sex:

_____

Date of Assessment_____

1. Present Mental Status:

Alert _____ Disoriented _____ Noisy _____ Depressed _____ Abusive _____

Oriented _____ Anxious _____ Quiet _____ Withdrawn _____ Noncompliant

Decisions Consistent & Reasonable _____ Lethargic _____ Suspicious _____ Unresponsive _____ Comments:

_____

_____

_____

_____

_____

_____

2. Activity / Mobility Transfers Locomotion:

Dependent for all position changes _____ Full Assist _____ Bedfast _____ Limited Assist _____

Wheelchair _____ OOB to chair _____ Supervision _____ Walker _____ Ambulatory _____ OOB ad lib

_____ Cane

Other (describe) _____

3. Diet / Nutrition:

Type of Diet_____

Chewing or Swallowing Problem s _____

NPO _____

Artificial Nutrition (PEG, TPN, PPN, etc.) or Hydration (IV) explain:

_____

_____

_____

_____

_____

H eight _____ W eight _____ Usual Weight Prior to Illness

4. List of All Allergies:

_____

_____

_____

5. Communication:

Language Spoken: English _____ other (specify) _____

Aphasia _____Speech Slurred or Garbled _____Non-communicative_____

6. Special Needs / Appliances / Equipment:

Oxygen (m ode of delivery and l/m in) _____ Incontinent of Urine _____

Tracheostomy (size & make) _____ Foley Catheter _____

Suction _____ ___ Incontinent of Feces _____

Humidifier _____ Ostomy (specify) _____

Nebulizer _____

Wound Care: (explain in detail site, origin, procedure)

_____

_____

_____

_____

_____

Other Challenges / Needs:

_____

_____

_____

_____

_____

7. Cooperative (describe and explain): _____

_____

_____

_____

8. Smoking: Currently Smokes _____ Packs per day _____ has Quit - When?