

**Freeport Health Centre
ADMISSION APPLICATION: GERIATRIC ASSESSMENT UNIT REFERRAL**

| |
|--------------------------------------|
| Client's name |
| Diagnosis/history of present illness |
| Physical status/presenting problem |

| FUNCTIONAL STATUS | | | | | |
|----------------------------|-------|-----------------------------|---------------|---------------|---------|
| I = Independent | | S = Supervision | | D = Dependent | |
| Min A = Minimum Assistance | | Mod A = Moderate Assistance | | | |
| | Score | Comment | | Score | Comment |
| Feeding | | | Grooming | | |
| Bathing | | | Bladder | | |
| Dressing | | | Bowel | | |
| Mobility | | | Other | | |
| Cognitive status | | | Communication | | |

| |
|--|
| Family / social support needs / home environment |
| Family response to application |
| Community services utilized (name of service and outcomes) |

| |
|--|
| Discharge goal (eg. return home) |
| Level of function required/expected to meet discharge goal |
| Focus of present treatment |
| Potential areas for improvement |
| Attachments: <input type="checkbox"/> History <input type="checkbox"/> Consults <input type="checkbox"/> Progress Notes <input type="checkbox"/> Pertinent diagnostic tests <input type="checkbox"/> Medication record <input type="checkbox"/> Care plan |

ADMISSION APPLICATION: DEMOGRAPHIC INFORMATION

PATIENT'S PERSONAL INFORMATION

| | | | | |
|--|--|------------------|----------------------------------|-----------------------------------|
| Last name | | First name | | <input type="checkbox"/> Male |
| | | | | <input type="checkbox"/> Female |
| Address | | Apt. # | City | Prov. |
| | | Postal code | | |
| Home telephone | | Present location | | |
| Date of birth <small>year / month / day</small> | | Age | <input type="checkbox"/> Single | <input type="checkbox"/> Married |
| | | | <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced |
| Religion | | Place of worship | | |
| Family physician | | Phone | Most Responsible Physician | |
| | | Fax | Phone | |
| | | | Fax | |

HEALTH INSURANCE INFORMATION

| | | | | |
|--|--|---|--|--------------|
| Is patient covered under Ontario Health Insurance Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Last name on Health Card:___ | | Health Insurance Number | | Version code |
| | | | | |
| Accommodation preferred <input type="checkbox"/> Ward <input type="checkbox"/> Semi-private <input type="checkbox"/> Private | | Insurance attached <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

EMERGENCY CONTACT INFORMATION

| | | | | |
|-----------------------------|---|---|-------|-------------|
| Next of kin/primary contact | | Relationship | | |
| Address | | City | Prov. | Postal code |
| | | Telephone (work) | | Ext. |
| Telephone (home) | | | | |
| Power of Attorney | <input type="checkbox"/> Personal care Name: | <input type="checkbox"/> Financial Name: | | |
| Substitute Decision Maker | | | | |

CLINICAL INFORMATION

| | | | | |
|---|--|--|---|--|
| Diagnosis | | | | |
| Infections MRSA <input type="checkbox"/> No <input type="checkbox"/> Yes VRE <input type="checkbox"/> No <input type="checkbox"/> Yes Other—specify | | | | |
| Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes Specify (attach sheet if necessary) | | | Diabetic <input type="checkbox"/> No <input type="checkbox"/> Yes | |

REFERRAL SOURCE

| | | | | |
|-------------------|-------|-------|---|--|
| Facility | | | Date <small>year / month / day</small> | |
| Contact person | Phone | Pager | Fax | |
| Alternate contact | Phone | Pager | Fax | |

INTERNAL — FREEPORT HEALTH CENTRE USE

| | | |
|---|---|---|
| Expected date of admission <small>year / month / day</small> | REH <input type="checkbox"/> GNR <input type="checkbox"/> DER <input type="checkbox"/> GER <input type="checkbox"/> PUL | CHR <input type="checkbox"/> PAL <input type="checkbox"/> ASE <input type="checkbox"/> RET <input type="checkbox"/> FEU |
| Actual date of admission <small>year / month / day</small> | Bed confirmed | |
| Notes | | |
| Attending physician | | Bed assigned |