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| ADMISSION FORM AND DATA SHEET |
| \*This form is completed at service initiation and updated as needed. Dated signatures are obtained at initiation and with changes. |
| PERSONAL INFORMATION |
| Name:  | Date of birth:        |
| Address:       | Home telephone number:       |
| Cell phone number:       | Email address:       |
| Date of admission or re-admission:       | Language(s) spoken:       |
| Guardianship type (self, private, public):       | Religious preference:       |
| Marital status:       | Place of Birth:       |
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| **IDENTIFYING CHARACTERISTICS** |
| Gender:       | Race:       |
| Height:       | Weight:       |
| Hair color:       | Eye color:       |
| Distinguishing characteristics/identifying marks:       |
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| **FINANCIAL INFORMATION** |
| Social Security Number (SSN):       | Medical Assistance Number:       |
| County of responsibility:       | PMI number:       |
| County of financial responsibility:       | Burial account number:       |
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| **MEDICAL INFORMATION** |
| Diagnoses:       |
| Allergies:       |
| Protocols (seizure, diabetic, etc.):       |
| Medical equipment, devices, or adaptive aides or technology used:       | Specialized dietary needs:       |
| **GENERAL CONTACT INFORMATION** |
| **Name** | **Address and telephone numbers** |
| Legal representative:       |       |
| Authorized representative:       |       |
| Primary emergency contact:       |       |
| Case manager:       |       |
| Family member:       |       |
| Family member:       |       |
| Other:       |       |
| Financial worker:       |       |
| Residential contact:       |       |
| Vocational contact:       |       |
| Other service provider:       |       |

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| **HEALTH-RELATED CONTACT INFORMATION** |
| **Name** | **Address and telephone numbers** |
| Primary health care professional:       |       |
| Psychiatrist:       |       |
| Other mental health professional:       |       |
| Neurologist:       |       |
| Dentist:       |       |
| Optometrist/Ophthalmologist:       |       |
| Audiologist:       |       |
| Pharmacy:       |       |
| Hospital of preference:       |       |
| Other health professional:       |       |
| Other health professional:       |       |
| **PARENTAL INFORMATION** |
| Father’s Name:  |  |
| Mother’s Name:  |  |
| Father’s Birthplace:  |  |
| Mother’s Birth Place:  |  |
| Parent’s Marital Status:  |  |
| **ADDITIONAL INFORMATION** |
| Reason for Admission: |  |
| Type and Legal Status of Admission: |  |
| Legal Competency Status: |  |
| Source of Support: |  |
| **DISCHARGE INFORMATION** |
| Date: |  |
| Reason for Leaving: |  |
| Released to: (Name & Address) |  |
| Relationship: |  |
| New Address: |  |
| Discharging Nurse: |  |
| Physician’s Approval | with\_\_\_\_ without\_\_\_\_ |
| Other Information: |  |
| **DEATH INFORMATION** |
| Date of death: | Time:\_\_\_\_\_am \_\_\_\_\_\_\_pm |
| Funeral Home: |  |
| Cause of Death: |  |
| Physician: |  |

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Person served and/or legal representative Date