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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: |
|  | | |
| **IDENTIFYING CHARACTERISTICS** | | |
| Gender: | | Race: |
| Height: | | Weight: |
| Hair color: | | Eye color: |
| Distinguishing characteristics/identifying marks: | | |
|  | |  |
| **FINANCIAL INFORMATION** | | |
| Social Security Number (SSN): | | Medical Assistance Number: |
| County of responsibility: | | PMI number: |
| County of financial responsibility: | | Burial account number: |
|  | | |
| **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