INDIVIDUAL'S INCORMATION

INDIVIDUAL'S INFORMATION				Last Upo	lated			
Name (Last, First, MI)	DOB		Residence Phone		Hospital Preference			
Address	Modicaio	1 ID		Medicare ID		Other Insurance		
Address	Medicaid ID			Wedicare ID		Other insurance		
	Language Spoken			Communication		Legal Status		
	Languag	је орокен		Communication		Logar Otatus		
	Religion							
	rtongion							
REASON FOR VISIT	1							
To Be completed at time of transfer:								
·								
Pre-sedation given prior to leaving residence:	Yes □	No □						
If YES to the above, names of medications:								
Does the individual have a guardian? Yes □	No □							
If YES, provide name, relationship, and contact number:								
CONSENT								
Person(s) Authorized to Give Consent:								
Individual								
Name (First and Last)		Relationshi	ip		T	elephone Numbers		
					(h	n)		
Address (City, State, Zip)					(v	v)		
					(c	,		
Name (First and Leat)		Dolotionah	in		•			
Name (First and Last)		Relationsh	пр			elephone Numbers		
Address (City, State, Zip)					(h	1)		
Address (City, State, Zip)					(v	v)		
					(c	:)		
ADVANCED DIRECTIVES								
Non-Hospital DNR Order In Effect? Yes	l No □	Unknown	пП		Attach Co	py of Order If Applicable		
	nown 🗆					py of Order If Applicable		
Other Yes No Unknown						py of Order If Applicable		
If YES to Other, specify (i.e. MOLST, Living Wi	ill).					r)		
DIET AND CONSISTENCY								
ALLERGIES								
Medication Allergies (list with description of read	ction if kno	own):						
Food Allergies (List)								
- , ,								
Other (Latex, environmental, etc.)								
MEDICATIONS (See Attached Copy of Curre	nt Medica	tion Admir	nistrat	ive Record)				

Routine medication given:

If Other, Specify:

## **READY TO GO FORM**

INIDIM	ואווחו	'S NAME	

Last Updated:	
Lasi Uuuaieu.	

INDIVIDUAL 5 NAME.							Last Updated:					
PRIMARY HEA	LTH CARE PR	OVIDER										
Name Address (City, State, Zip)							Phone:					
		ridarood (Oily, Otato, Lip)										
							Fax:					
PHARMACY												
Name Address (City, State, Zip)						Zip)		Phone	<del></del>			
							Fax:					
MEDICAL HIST	TORY		<u> </u>					<u> </u>				
Diagnosis												
Past Procedure	s/Surgery											
BASELINE												
Vital Signs	Т	Р		R		BP		HT	٧	VT	WT Date	
Neurological/Me	ental Status (des	ı scribe tyr	pical)									
	(		,									
Behavioral (PIC	A, etc.)											
,												
IMMUNIZATIO	NS (most recen	nt)										
Tetanus Date Pneumovax Date Infl			nfluenza	luenza Date Varicella Date Va			Varic	Varicella Status		Other		
TB Status (mm) PPD Date			He	Hepatitis B Status Hepatitis 0			itis C.S	C Status				
To Glatus (IIIIII)   FFD Date			110	Tiepatitis B Otatus				Clarac				
	CONTACT INFO		ON									
Agency Name: Administrator/designee							Telephone					
						Day Time:						
DNI							After Hours: Telephone					
RN												
						Day Time:						
Care Manager							After Hours: Telephone					
- Care manager						Day Time:						
							After Hours:					
Other Relationship							Telephone					
, i							Day Time:					

After Hours:

## Last Updated:\_ **INDIVIDUAL'S NAME:** ADDITIONAL INFORMATION Other: