The German Home

374 Howard St
Lawrence MA 01840
978-682-5593
Fax 978-681-9300

Applicants Name_____ (Please Circle) Male/ Female

Address _____Birth date _____

Citizen of United States Yes/ No If no provide Resident Alien Registration number _____

Is applicant now at home (Circle one) yes/no Place of Birth _____

Social Security Number _____ Medex Number _____

Medicare Number _____Mass Health Number _____

Private Health Insurance _____

Sources of Income (Please list all sources of income)
_____

_____

Monthly Income total:_____

Name of Primary Care Physician _____Telephone# _____

Next of Kin:_____Telephone Number_____

Relationship_____--_____

Marital Status:_____ Religion: _____

Name of Previous Nursing Home or Rest Home : _____

Dates there? _____

Interested in admission (when)_____

All information will be safeguarded in compliance with the Federal and State regulations of HIPPA

Referred by _____

Reason for seeking admission _____

Name of Hospital and Social Worker if currently inpatient. _____

_____

Telephone number_____

Please provide medical information. Please circle all that apply.

Visual difficulties: Cataracts, Glaucoma, Wear Glass or Contact Lenses, Frequent eye infections Blindness

Hearing: Deafness, or hard of hearing, Hearing Aids, Discharge from Ears,

Respiratory: Chronic Cough, Emphysema, Bronchitis, COPD, Shortness of Breath, Asthma, Wheezing, Allergies, Hay Fever, Frequent respiratory infections.

Mental Health : Bipolar, Schizophrenia, Anxiety, Depression , Excessive Worry, Suicidal Thoughts, Attempted Suicide , Obsessive thoughts, Compulsive thought.

Ambulation : Uses a Walker, Cane or Wheel Chair? , Do you wear a Brace or Prosthesis? I can you put it on Myself, I need assistance putting it on. I can climb stairs. I can exit the building in case of emergency. I would like first floor.

Independence : Do you need assistance with bathing or dressing? Do you manage your money yourself or does someone assist you.

Sleeping habits: Needs sleep aids, sleep walks, wakes at night, uses CPAP machine, likes Window open, uses night Light.

Toileting: Uses Toilet without help. Needs assistive equipment /device, needs assistance from a person Problems with Bowels or Bladder Catheter, Colostomy, incontinence apparel all the time, only at night .

Behavioral issues: Visits with others, Helps others, Apprehensive, Lethargic, Withdrawn, Tearful, Irritable, Agitated at times , Restless, Wandering / Elopes.

Communication: English, Spanish, Verbally communicates, American Sign Language, Does not Communicate.

Orientation: Knows self and Family members, Knows where they are, Knows their correct age and the year.

Please let us know of any additional information so that we can best provide appropriate care.

_____
_____
_____
_____

Diabetes, High Blood Pressure, Heart Problems, Stroke, Cancer, Epilepsy, Liver Disease, Kidney Disease Please give specifics:

_____
_____
_____
_____
_____
___

Signature of Person completing this form and contact Information:

_____
_____
_____
_____

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