

Resident's Name: _____ Facility Name: _____

ADMISSION / DISCHARGE INFORMATION

Date of Admission: _____ County: _____

Admitted from: Own Home Hospital NH OMH Other (specify): _____

Address Admitted from (Street, City, State, Zip): _____

Discharge Date: _____ Discharge to: Own Home Hospital NH OMH

Other (Specify): _____

Address Discharged to (Street, City, State, Zip Code): _____

Reason for Discharge: _____

SECTION 1: PERSONAL DATA

Date of Birth: ____/____/____ Gender: M F Status: Married Single Divorced Widowed Partner
Month Day Year

NOTIFY IN CASE OF EMERGENCY

Name _____

Relationship _____

Home: _____ Work: _____

Cell Phone: _____ Other: _____

Address _____

City _____ State _____ Zip _____

ATTENDING PHYSICIAN

Name _____

Address _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

AREA HOSPITAL / CLINIC OF CHOICE

Name _____

Address _____

Additional Information: _____

Resident's Name: _____ Facility Name: _____

SECTION 1: PERSONAL DATA Cont.: HEALTH INSURANCE

Insurer _____ ID # _____
Medicaid No. _____
Medicare No. _____
Prescription Drug Plan (if any) _____
Plan ID # _____
Other Health Care Coverage _____

PHARMACY

Pharmacy(ies) _____

Phone _____ Phone _____
Address(es) _____

City _____ State _____ Zip _____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: _____
Address (if different from ALR): _____

Resident's Representative: _____
Relationship: _____
Address: _____
Phone: Home _____
Work _____
Cell _____

Resident's Representative: _____
Relationship: _____
Address: _____
Phone: Home _____
Work _____
Cell _____

Residential Background (born/raised, lived most of life): _____

Occupational/Educational Background: _____

Religious Affiliation (if any): _____ Place of Worship: _____ Phone: _____

Health Care Proxy: Yes No _____ (Name) DNR: Yes No

Power of Attorney: Yes No _____ (Name) Living Will: Yes No

Burial Instructions: _____
