



# ***Shrewsbury* Nursing & Rehabilitation**

## Application for Admission

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Marital Status: \_\_\_\_\_ Name of spouse: \_\_\_\_\_

## Financial Information

Medicare number: \_\_\_\_\_ Mass Health number: \_\_\_\_\_

Co- insurance company: \_\_\_\_\_

Member number: \_\_\_\_\_ Group number \_\_\_\_\_

Long Term Care Insurance Company: \_\_\_\_\_

Pension Amount: \_\_\_\_\_ Social Security amount: \_\_\_\_\_

Social Security number: \_\_\_\_\_ SS Direct Deposit: Y / N

Bank account location: \_\_\_\_\_ Account number: \_\_\_\_\_

Name(s) on account: \_\_\_\_\_

Bank account location: \_\_\_\_\_ Account number: \_\_\_\_\_

Name(s) on account: \_\_\_\_\_

Medical Information

Primary Care Physician \_\_\_\_\_ Tel. \_\_\_\_\_

**Medical History: (list all diagnoses)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Living Situation: (circle all that apply)**

- |                      |                  |                          |
|----------------------|------------------|--------------------------|
| Home alone           | home with spouse | home with family         |
| Home health aide     | meals on wheels  | long term care center    |
| Adult day health     | memory unit      | assisted living facility |
| In-law apartment     | senior housing   | rest home                |
| Resides out of state |                  |                          |

**Current functional status; (circle all that apply)**

- |                              |                         |                             |                 |
|------------------------------|-------------------------|-----------------------------|-----------------|
| Walks independently          | uses walker             | uses cane                   | uses wheelchair |
| Assistance for bathing       | assistance for dressing | assistance for eating       |                 |
| Decline in short term memory | wanders                 | decline in long term memory |                 |

**Current functional status continued;**

Hearing loss	legally blind	weekly dialysis	O2 dependent
Incontinent	adult briefs	skin breakdown	sleep disorder
C-pap	power wheelchair	raised toilet seat	tub seat

**Please list any dietary restrictions or preferences here;**

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**Additional Information;**

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**Admission Committee only below this line**

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**Room # \_\_\_\_\_ Nursing Station \_\_\_\_\_**

**Long term \_\_\_\_\_ Short term \_\_\_\_\_ Respite care \_\_\_\_\_**

**Date of Transfer \_\_\_\_\_ Estimated arrival time \_\_\_\_\_**

**SNRC MD \_\_\_\_\_ Approved \_\_\_\_\_ Denied \_\_\_\_\_**

**Reason for denial**

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