



Application

Potential resident information:

Mr. Mrs. Miss _____
Other Title First Name MI Last Name

Preferred Name _____ Birth date ____ / ____ / ____ Marital Status _____

Current Address _____

Person completing this form:

Name _____ Relationship _____

Address _____

Telephone: _____ e-mail _____

Memory problem? yes no If yes, for how long? _____

- Has this condition been evaluated? yes no
- If yes, evaluation was performed by: Name: _____

Diagnosis: _____

Primary Caregiver

Name _____ Relationship _____

What are the current living arrangements? _____

- What supportive services are provided? _____
- _____

Describe the person's cognitive abilities in the following areas.

Memory _____

Judgment _____

Language _____

Responsiveness to requests /instructions _____

Describe the amount of assistance required in the following activities (e.g., independent, cueing required, assistance, total assistance)

Dressing _____

Mealtimes _____

Bathing _____

Toileting _____

- Is the person continent? yes no _____
- Able to walk independently? yes no (requires assistance)
- Assistive devices used? cane walker wheelchair

Does the person wander? (e.g., paces, “wants to go home”, etc)

Describe any challenging behaviors? (e.g., verbally/physically aggressive, sleep problems, resistive to care, etc.)

Describe the person's personality before the illness and today. (The following words may be helpful: content, extrovert, friendly, happy, independent, introvert, reserved, sad, serious, suspicious, timid)

Before the illness _____

Today _____

Describe a typical day for this person.

Power of Attorney

- Has a durable medical power of attorney been designated? yes no
Name _____ Phone _____
- Has a durable financial power of attorney been designated? yes no
Name _____ Phone _____
- Has an advance directive or living will been completed? yes no

What type of room is preferred? Private Semi-private Either

How soon is placement desired? _____

Please attach copies of the following records:

- a.** Current medications **b.** Most recent physical **c.** Diagnosis

To be completed by Hale Ku'ike staff:

Date application received _____ Date of last physical _____

Date of last TB test _____ Details _____



Admission Guide for Physicians

Hale Ku'ike is licensed by the Hawaii Department of Health as an Adult Residential Care Home. The following items are required by the Department of Health prior to Admission.

Thank you for your assistance.

Resident Admission Medical and Personal History

- This form is required for admission

All Medications / Treatment Orders

Per State regulations, all medications/treatment orders will need to be called into the pharmacy of choice. If Pharmerica will be used, their number is 832-8232 option #4.

Tuberculosis Clearance:

PPD record must be performed within 1 year prior to admission.

- A two-step TB skin test (PPD) is required.
 - 1st step PPD given and read 2-3 days later.
 - 2nd step will be given one to three weeks after the 1st test and read 2-3 days later.
- If the tuberculin skin test is positive (a record of this must be in resident's file) and a chest x-ray specifically for TB Clearance stating "negative for TB - normal chest" or "no active TB disease found" is required. A yearly chest x-ray thereafter shall be required for three successive years.



Resident Admission Medical and Personal History

Name: _____

Date of Birth: _____

Resident's pertinent past history: _____

Height: _____

Weight: _____

B/P: _____

Presents no symptoms, such as skin lesions, respiratory tract symptoms, diarrhea, or other symptoms to indicate the presence of infectious diseases which may harm others. Yes No

Vision impairment? Yes No Prescription glasses? Yes No

Hearing impairment? Yes No Hearing aid? Yes No

Allergies to Medication: _____ Allergies to Food or Other: _____

Teeth _____ Mouth _____ Throat _____

Circulation/Heart: _____

Respiratory System: _____

GI System: _____

Urinary System: _____

Nervous System: _____

Extremities: Arms _____ Legs _____ Skin: _____

Diagnoses: _____

Medications/Treatments: _____

Diet: _____

History of chronic mental illness: Yes No

If "yes", explain: _____

Is resident being treated for chronic mental illness? Yes No

Psychiatric follow-up due _____ Phone: _____

Psychiatrist _____ Phone: _____

Medical follow-up due _____ Phone: _____

Physician _____ Phone: _____

Any history of violent, destructive behavior to persons or property, or wandering behaviors:

Behavioral modification advised: _____

CPR Status: In the event of cardiac arrest CPR / No CPR will be initiated.

Generic equivalent drugs may be used: Yes No

PPD and Flu Vaccine may be given yearly: (date vaccine last given: _____) Yes No

Pneumo vaccine may be given (date last given: _____) Yes No

Routine vital signs and weight monitoring Yes No

Dental, podiatry, optometry as needed Yes No

May take part in activities as tolerated Yes No

May take part in daily exercise program as tolerated Yes No

May take part in therapeutic walking exercise under supervision of facility staff Yes No

May apply steri-strips to skin tears PRN and may apply Neosporin / bacitracin BID PRN until healed Yes No

May go out on pass with family, friends, staff with medications Yes No

The Resident is certified as: **ARCH** **Expanded Care / ICF**

- Resident must be at ARCH or Expanded Care/ICF level of care to be admitted to Hale Ku'ike.

Physician/APRN Signature

Date

Phone Number

Physician/APRN Name