



Date submitted: _____

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: _____

Who is the Personal Care Physician? _____

- Please list other medical diagnosis: _____

- What are the current medications? _____

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
- Is the person on a special diet ordered by the physician? Chopped Fine chopped Pureed
Thickened liquids? yes no
- Able to walk independently? yes no (requires assistance)
- Assistive devices used? cane walker wheelchair
- Is the person diabetic? yes no If so, are insulin injections needed? yes no

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

Describe any challenging behaviors. (e.g., verbally/physically aggressive, 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.

Please describe sleep habits or concerns.

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

Which location is preferred? Nu'uuanu Bayside Pali First available

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

How soon is placement desired? _____

How did you hear about Hale Kū'ike? _____

“Nuuanu”

Hale Kū'ike, LLC
95 Kawanānakoā Place
Honolulu, HI 96817
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Fax: 808-595-6771

“Pali”

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Phone: 808-525-6770
Fax: 808-525-6776

“Bayside”

Hale Kū'ike Bayside, LLC
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