EMERGENCY ROOM/HOSPITAL ADMITTANCE FORM

Form to be completed by residential staff prior to bringing the individual with mental retardation to the Emergency Room or admitting the individual to the hospital.

Date: _____ Completed by: _____ Relationship to Individual: _____

Name: _____ Nickname/Likes to be called: _____

DOB: _____ Soc Sec #: _____

Address: _____

_____

Phone #: _____

Health Insurance (Type & Numbers)

Primary: _____

Secondary: _____

Allergies: _____

Living Status: Group Home____ Family Living____ Lives Independently _____ Other_____

Nursing Supports Available at provider agency? (circle) Yes or No; RN and/or LPN Name: _____

Emergency Contacts

Name (Provider Agency):_____
Phone Number: _____
Phone Number (After Hours): _____

Name (Family): _____
Relationship: _____
Phone Number: _____

County Contact Person: _____
Phone Number: _____
Phone Number (After Hours): _____

Primary Care Physician: _____
Phone Number: _____

Neurologist: _____
Phone Number: _____

Psychiatrist: _____
Phone Number: _____

Reason for ER visit today:

Current Medical Problems/Diagnoses:

Level of Mental Retardation (circle one):
Mild Moderate Severe Profound

Consent Status:

- ❑ CAN give own consent
- ❑ CANNOT give own consent. Has a Legal Guardian.
  Legal Guardian: _____ Phone Number: _____
- ❑ CANNOT give own consent. Does not have a Legal Guardian. Has a Substitute Healthcare Decision Maker.
  Name: _____ Phone Number: _____
  Medical Durable POA: _____ Phone Number: _____

Resuscitation Status:

- ❑ DNR****
- ❑ Full Resuscitation

If DNR, List Reason: _____ Date DNR Given: _____ By Whom: _____

Consent for Release of Information to Provider(circle one): Yes No

Date of Last Tetanus: _____ Date of Last PPD: _____ Date of Last Flue Shot: _____
Date of Last Pneumovax: _____ Date of Hepatitis B Vaccines: _____

Communication
- Able to Communicate
- Communication Difficulties/Uses verbalizations
- Communication Difficulties/Uses gestures
- Not able to communicate needs
- Unable to use call bell

Vision:
- Normal
- Low Vision
- Blind
- Wears glasses
- Wears contact lenses

Hearing:
- Normal
- Hard of Hearing (Left/Right)
- Deaf (Left/Right)
- Hearing Aid (Left/Right)

Supportive Devices:
- Padded side rails
- Splints
- Braces
- Helmut
- Other _____

Toileting Ability:
- Continent
- Needs Assistance
- Incontinent
- Catheterized
- Other_____

Medication Administration:
- Independent/Self Medicates
- Medication Administered by Staff

Dining/Eating
- Independent
- Needs Assistance
- Totally Dependent
- Fed Through a Tube
- Other _____

Diet Texture
- Regular
- Chopped
- Ground
- Puree
- Thickened Liquid

Diet Type_____
Last Meal Eaten _____

Ambulation:
- Independent / Steady / Unsteady
- Needs Assistance / 1 Person / 2 Person
- Walker / Cane / Crutches
- Wheelchair / Non-Ambulatory

Personal Hygiene
- Independent
- Special Needs _____

Oral Hygiene
- Independent
- Special Needs _____
- Dentures (Upper/Lower/Partial)

Head of Bed Elevated (Yes/No)

SPECIAL NEEDS

Usual Response to Medical Exams: Cooperates Partially Cooperates Resistant/Becomes Agitated Fearful/Anxious

Any sedation required for clinical visits_____
Special positioning required for examination _____
Staff required for assistance with exams _____
Requires limited waiting periods for exams
Prefers early day appointments Prefers end of day appointments
Special communication device/method _____

Pain Response: Normal Unique _____

Medical History: Known Unknown
For information, contact: _____ Relationship _____
Phone _____ Address_____

SURGICAL

List all previous surgeries and dates (most recent first):
_____
_____
_____

Any previous problems with anesthesia:
No Yes _____

List any serious trauma or broken bones:
_____
_____

MEDICAL

List all serious medical illnesses (e.g. pneumonia, heart attack) and ongoing medical problems (e.g. diabetes, high blood pressure, epilepsy) _____
_____
_____

PSYCHIATRIC

List all major behavioral and psychiatric diagnoses (e.g. depression, schizophrenia, self-injurious behavior)
_____

WOMEN'S HEALTH

Currently Pregnant: Yes No
Past History of Childbirth Yes No
Age menstruation started_____
Age menstruation stopped _____
Still menstruating
Date of Last PAP_____
History of Abnormal PAP?
Yes No _____
Date of Last Mammogram _____

MEN'S HEALTH

Date of Last Prostate Exam_____
Date of PSA_____
Normal Abnormal N/A