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: Relat	tionship to Individual:				
Name: Nickname/Likes to be called:						
DOB: Soc S	dec #:	Health Insurance (Type & Numbers)				
Address:						
Phone #:						
Allergies:	Parity Living Live Ld	ependently Other				
Nursing Supports Available at p	rovider agency? (circle) Yes or I	No; RN and/or LPN Name:				
Emergency Contacts						
Name (Provider Agency):	N	ame (Family):				
		onship:				
Phone Number (After Hours):	Ph	one Number:				
County Contact Person:						
Phone Number:						
Phone Number (After Hours):						
Primary Care Physician:		Reason for ER visit today:				
Phone Number:						
Nauralagist						
Neurologist:Phone Number:		Current Medical Problems/Diagnoses:				
Thone (tumber)	4	Cuttent Wedter Trootenis Diagnoses.				
Psychiatrist:						
Phone Number:	-	Level of Mental Retardation (circle one):				
C		Mild Moderate Severe Profound				
Consent Status:						
□ CAN give own consent□ CANNOT give own co	nsent. Has a Legal Guardian.					
		Phone Number:				
□ CANNOT give own co	nsent. Does not have a Legal Gu	ardian. Has a Substitute Healthcare Decision				
Maker.						
		Phone Number:				
Medical Dural	ble POA:	Phone Number:				
Resuscitation Status:						
□ DNR****						
 Full Resuscitation 						
If DNR, List Reason:	Date DNR C	Given: By Whom:				
Consent for Release of Informat	ion to Provider(circle one): Yes	No				
Date of Last Tetanus:	Date of Last PPD:	Date of Last Flue Shot:				
Date of Last Pneumovax:						



	officulties/Uses verbalizations of ifficulties/Uses gestures unicate needs	Medication Administ Independent/Self M Medication Admin Dining/Eating Independent Needs Assistance Totally Dependent Fed Through a Tub Other Diet Texture	fedicates istered by Staff	Ambulation: Independent Needs Assistance Walker Wheelchair Personal Hygiene Independent Special Needs Oral Hygiene Independent	Steady Unsteady 1 Person 2 Person Cane Crutches Non-Ambulatory	
Wears contact lenses		Regular Chopped		Special Needs Dentures (Upper/Lower/Partial)		
Supportive Devices: Toileting Ability: Padded side rails Splints Needs Assistance Braces Incontinent Helmut Catheterized Other Other		Ground Puree Thickened Liquid Diet Type Last Meal Eaten		Head of Bed Elevated (Yes/No)		
Any sedation rec Special positioni Staff required fo Requires limited Prefers early day Special commun	Medical Exams: Cooperates quired for clinical visits ing required for examination r assistance with exams waiting periods for exams appointments ication device/method	Prefers end of da	y appointments			
Pain Response:	Normal Unique					
The state of the s	formation, contact:	Address	Rela	ationship		
SURGICAL List all previous su	urgeries and dates (most recent	materia.	WOMEN'S H Currently Pregr Past History of Age menstruati	EALTH)	
No Yes	lems with anesthesia:		Still menstruating Date of Last PAP History of Abnormal PAP? Yes No Date of Last Mammogram			
List any serious trauma or broken bones:			MEN'S HEAL	тн		
attack) and ongoin high blood pressur	dical illnesses (e.g. pneumonia g medical problems (e.g. diabe e, epilepsy)	tes,	Date of Last Pr Date of PSA	ostate Examrmal Abnormal N/A		
	vioral and psychiatric diagnose chizophrenia, self-injurious bel					

