



中華頤養院

SOUTH COVE MANOR

120 Shawmut Avenue

Boston, Massachusetts 02118-2293

Telephone: (617) 423-0590 Telefax: (617) 292-7922

Pre - Admission Referral Form

NAME: _____ DOB: _____ SEX: _____ MEDICARE #: _____

ADDRESS: _____ MEDICAID #: _____

RESPONSIBLE PARTY: _____ OTHER INSURANCE: _____

PHONE: _____ EVER CARE: _____

DATE OF ADMISSION TO HOSPITAL _____

DX/Pertinant medical information: _____

Table with columns: BEHAVIOR, YES, NO. Rows include ALERT, ORIENT PERSON, ORIENT PLACE, ORIENT TIME, CONFUSED, NOISY, WANDERS, COMBATIVE, OTHERS.

Table with columns: MOBILITY, INDEPEND, ASSISS, DEPENDANT. Rows include AMBULATE, W/C, OTHER.

SKIN CONDITION

DECUBITIS: _____

TREATMENTS/PROCEDURES: _____

OTHER NEEDS:

O2, SPECIAL DIET, SPECIAL EQUIPMENT

Table with columns: ADLS, INDEPEND, ASSIST, DEPENDANT. Rows include BATHE, GROOM, DRESS, EATING.

ANY OTHER RELEVANT INFO:

WEIGHT _____ WEIGHT CHANGE _____

TUBE FEEDING _____

Table with columns: TOILET, CONTINENT, INCONTINENT. Rows include BLADDER, BOWEL.

MEDICATIONS:

INFECTION STATUS YES / NO _____

PPD RESULTS: _____ CHESTX-RAY DONE: YES / NO

PNEUMO VAC RECEIVED: YES / NO, DATE RECEIVED: _____

FLU VAC RECEIVED: YES / NO, DATE RECEIVED: _____

REFERRAL MADE BY: _____ DATE _____ PHONE _____

FOR INTERNAL USE ONLY

DATE RECEIVED REFERRAL _____

FOLLOW UP PHONE CARD MADE BY _____ DATE _____