Applicant's Name: _____ **Date:** _____

Rosary Hill Home

600 Linda Avenue
Hawthorne, NY 10532
Tel: (914) 769-0114 Fax: (914) 769-3916

APPLICATION AND PRE-ADMISSION FORM

Please Read All Information Carefully
All Questions Must Be Answered Before the Application Can Be Reviewed and Processed

Requirements for Admission to Rosary Hill Home:

Documented proof of a diagnosis of incurable cancer is required. This may be a Pathology Report, a CAT Scan, a Biopsy Report, or other requested information.

Rosary Hill Home is a free home for those who are financially unable to afford nursing care elsewhere. This means:

- the patient has no insurance coverage
- if the patient has insurance coverage, such coverage is not adequate to cover the cost of a stay in a nursing facility
- the patient does not have other assets that would cover the cost of nursing care

Rosary Hill Home accepts no payment of any kind,
including Medicare, Medicaid, private insurance or private pay.
Financial need is a requirement for admission.

Patients and families must be informed that the care provided by Rosary Hill Home is palliative, not curative. All treatments must be completed before the patient is accepted. Medications and all ancillary orders will be prescribed by our physicians.

Do Not Resuscitate - As only persons with incurable cancer are admitted to Rosary Hill Home and as Rosary Hill Home provides only palliative care, all patients must submit a valid "Do Not Resuscitate" (DNR) Order prior to admission.

Palliative Care is a concept of care which employs medical and nursing care as well as specific ancillary services, when indicated, whose primary objective is the comfort and overall well-being of the incurable/terminal individual. No treatment is employed which would overburden the individual, yet full support is offered for basic physical needs as well as spiritual, psychological, and emotional needs. Individuals, while experiencing similar diagnoses, may have different needs or symptoms associated with their disease and secondary diagnoses; hence personalized medical or nursing plans of care based on individual needs and symptoms are developed.

Rosary Hill Home complies with all applicable federal, state, and local civil and human rights laws with regard to employment and provision of services. Patients are welcome regardless of age, color, creed, sex, national origin, handicap, or marital state.

I AM AWARE OF AND ACCEPT THE POLICIES STATED ABOVE.
Signature of patient / responsible person required for admission:

Signature_____ Relationship_____

Name (Printed)_____ Home Phone Number_____

Address_____ Work Phone Number _____

_____

Applicant's Name: _____
Last First Middle

Date of Birth:_____
Month / Day / Year

Male/Female:_____

Race:_____

Address:_____
Number & Street Apt. Number

Religion:_____

_____
City State ZIP Code

Marital Status:_____

Social Security Number:_____

Height:_____

Weight:_____

Veteran: ☐ Yes ☐ No

Branch of Service:_____ Years:_____

Ambulatory:_____

Lived Alone: ☐ Yes ☐ No

Highest Level of Education:_____

Occupation:_____

Place of Birth:_____

Admitted From: ☐ Home ☐ Hospital ☐ Other (Specify): _____

Location:_____

If admitted from home, date of most recent hospitalization:_____
Month / Day / Year

Family / Responsible Person Contacts

* Please indicate if the person listed as a contact has Power of Attorney or other special legal relationship to the patient.

Primary Contact

Name:_____ Relationship:_____

Address:_____
Number & Street Apt. Number City State ZIP Code

Phone Numbers: Cellphone #: _____ Home #:_____ Work #:_____

Name:_____ Relationship:_____

Address:_____
Number & Street Apt. Number City State ZIP Code

Phone Numbers: Cellphone #: _____ Home #:_____ Work #:_____

Name:_____ Relationship:_____

Address:_____
Number & Street Apt. Number City State ZIP Code

Phone Numbers: Cellphone #: _____ Home #:_____ Work #:_____

Nursing Assessment

Applicant's Name:_____ **Age:**_____ **Sex:**_____

1. Present Mental Status

☐ Alert ☐ Disoriented ☐ Noisy ☐ Depressed ☐ Abusive

☐ Oriented ☐ Anxious ☐ Quiet ☐ Withdrawn ☐ Noncompliant

☐ Decisions Consistent & Reasonable ☐ Lethargic ☐ Suspicious ☐ Unresponsive

Comments _____

2. Activity / Mobility

	Transfers	Locomotion	
☐ Dependent for all position changes	☐ Full Assist	☐ Gerichair	☐ Other _____
☐ Bedfast	☐ Limited Assist	☐ Wheelchair	
☐ OOB to chair	☐ Supervision	☐ Walker	
☐ Ambulatory	☐ OOB ad lib	☐ Cane	

3. Diet / Nutrition

Type of Diet _____

Chewing or Swallowing Problems _____

NPO _____

Artificial Nutrition (PEG, TPN, PPN, etc.) or Hydration (IV) explain _____

_____

Height _____ Weight _____ Usual Weight Prior to Illness _____

4. List of All Allergies _____

5. Communication

Language Spoken: ☐ English ☐ Other (specify) _____

☐ Aphasia ☐ Speech Slurred or Garbled ☐ Non-communicative

6. Special Needs / Appliances / Equipment

☐ Oxygen (mode of delivery and l/min) _____ ☐ Incontinent of Urine

☐ Tracheostomy (size & make) _____ ☐ Foley Catheter (specify) _____

☐ Suction (specify) _____ ☐ Incontinent of Feces

☐ Humidifier ☐ Ostomy (specify) _____

☐ Nebulizer (specify) _____

Wound Care (explain in detail site, origin, procedure) _____

_____

_____

Other Issues / Needs _____

_____

7. Restraints (describe and explain) _____

_____

8. Smoking: ☐ Non-Smoker ☐ History of Smoking (Years) _____ ☐ Currently Smokes - Packs per day _____

9. History of Alcohol or Drug Abuse: ☐ No ☐ Yes, (please explain) _____

_____

Nurse / Caregiver Signature _____

Print Name _____

Telephone Number _____

Medical Summary

Applicant's Name:_____ **Age:**_____ **Sex:**_____

Primary Diagnosis:_____

Secondary Diagnoses:_____

_____

Primary Site of Malignancy:_____ Date of onset:_____

A Pathology report and/or appropriate scans and lab results supporting the diagnosis MUST BE ATTACHED.

Presenting Symptoms:_____

Prognosis / Stage of Illness:_____

Brief Medical Summary and Course of Treatment:_____

_____

_____

_____

TB Screen: PPD (required):_____
Results (in mm) Date

Chest X-Ray (attach report or write):_____
Results Date

Pneumococcal vaccine:_____ Influenza vaccine:_____
Date Date

Infectious Diseases over the past 90 Days:_____

List Current Medications:_____

_____

Allergies:_____

If there is a history of Mental Illness, please explain:_____

_____

Please stamp, type, or print the Name, Address, and Telephone Number of Physician:

_____
Signature of Physician Date