

Arthur-Rose Assisted Living Inquiry/Application Form

Date _____

(circle one) **CALL** or **VISIT**

CALLER INFO

Caller's Name _____

Home Phone (_____) _____ Work Phone (_____) _____

Address _____

Relationship to Prospective Resident _____

Email Address _____

PROSPECTIVE RESIDENT INFO

Prospective Resident's Name _____

(circle one) **WIDOWED** **MARRIED** **SINGLE** (circle one) **MALE** or **FEMALE**

Should we contact prospective resident? (circle one) **YES** or **NO**

Home Phone (_____) _____

Address _____

Date of Birth: _____

Power of Attorney _____
(Healthcare)

Activated? **YES** or **NO**?

Financial POA _____

PRESENT LIVING SITUATION

<input type="checkbox"/>	Own home or apartment	<input type="checkbox"/>	Hospital
<input type="checkbox"/>	Living with Relatives	<input type="checkbox"/>	Nursing Home
<input type="checkbox"/>	Retirement Community	<input type="checkbox"/>	Other Assisted Living Facility

CONCERNS OR NEEDS

	Bathing		Nutrition/meals		Recent falls
	Grooming		Special Diet		Ambulation
	Dressing		Hearing		Safety
	Toileting		Vision		Medications
	Incon. Product management		Memory Loss		Wheel chair
	Isolation		Wandering		Housekeeping/laundry

MEDICAL INFORMATION

	Dementia		CHF		GI Issues
	High Blood Pressure		Parkinson's		Cancer
	Hx Stroke or TIA's		Heart Problems		Kidney Disease
	Hx Heart Attack		Respiratory Issues		Mental Illness
	Diabetis		Chronic Skin Cond		Failure to Thrive

MD Name: _____ Clinic Preference: _____

Current Pharmacy: _____ Hospital Preference _____

List all Allergies:

List Current Meds:

Preferences

Tour Date: _____ Tour Time: _____

Room Preference: # _____ Move In Date: _____

Financial Information

Source of Payment: Private County Family Insurance Other

Staff Signature/Date: _____