Hartford HealthCare Senior Services
Short Term Rehab Application

Vital Statistics

Name ________________________________ Telephone ______________

Address ______________________ Town __________ State ____ Zip Code ________

Date of Birth ________________ U.S. Citizen ❏ Yes ❏ No

Marital Status __________ Religion ____________ Veteran ❏ Yes ❏ No ❏ Male ❏ Female

Medical Information

Date of Admission to Hospital (Surgery Date) ______________________________

Reason for Admission to Hospital ______________________________

Name of Hospital ______________________________

Surgeon ____________________ Primary Care Physician ____________________

____

Past Medical History ______________________________

____

Allergies ______________________________

Current Medications ______________________________

____

Diet ______________________________ HT ________ WT ________

Mental Status:

❏ Alert ❏ Oriented ❏ Confused ❏ Disoriented ❏ Forgetful

❏ Vague ❏ Non-responsive ❏ Depressed

Behavior Patterns:

❏ Cooperative ❏ Wanders ❏ Paces ❏ Combative ❏ Verbally Abusive

❏ Resistive to Care ❏ Easily Agitated ❏ Other ______________________________

Continence:

❏ Continent ❏ Incontinent

❏ Foley Catheter ❏ Suprapubic Catheter ❏ Texas Catheter (External Device)

❏ St. Catheter ❏ Colostomy ❏ Ileal Conduit

Oxygen/Liters ______________________________

Pace Maker ❏ Yes ❏ No Date Inserted ______________________________

Prosthesis (Type) ______________________________

History of Psychiatric Problems or Disorders? (Include Details and Dates of Hospitalization) ______________

____

History of Alcohol or Substance Use? If Yes, Describe ______________________________

Smoker ❏ Yes ❏ No

All Hartford HealthCare communities are non smoking.

Other Physician(s) ____________________

Advance Directives ❑ Yes ❑ No

If Yes, Please indicate: ❑ POA ❑ DPOA ❑ HCA ❑ Living Will ❑ Organ Donor ❑ Conservator

During the last 60 days, has there been a stay in the hospital or nursing facility? ________ If so, please indicate where and when stay took place. ____________________

____

Have Home Care Services been used in the past? ____________________

If so, please indicate which agency ____________________

Emergency Contacts:

Primary Contact

Name ____________________ Relationship ____________________

Address ____________________ Home Phone ____________________

Town ____________ Zip Code ________ Work Phone ________ Cell Phone ________

Secondary Contact

Name ____________________ Relationship ____________________

Address ____________________ Home Phone ____________________

Town ____________ Zip Code ________ Work Phone ________ Cell Phone ________

Insurance Information:

Social Security Number ____________________ Medicare Number ____________________

Health Insurance Plan ____________________ Policy # ____________________

Medicare Supplement ____________________ Policy # ____________________

Medicaid Number (Title 19) ____________________ Pending? ❑ Yes ❑ No

Medicaid Caseworker's Name ____________________ Phone ____________________

Medicare Prescription Plan ____________________ Policy # ____________________

Copies of cards enclosed (back and front) ❑ Yes ❑ No

(Name and information of person completing application)

Name ____________________ Phone No. (home) ____________________

Address ____________________ Phone No. (work) ____________________

Town ____________________ State ________ Zip Code ____________

Realtionship ____________________ ____________________

Signature of person completing application