

Admission Application



You have contacted this facility and indicated a desire to be considered for admission. Your name will be placed on our waiting list after you substantially complete and return this application.

Above applies to:

- Jerome Home
- Jefferson House
- Southington Care Center

SMOKE FREE ENVIRONMENT

975 Corbin Avenue • New Britain, Connecticut 06052 • 860.229.3707
3 John H. Stewart Drive • Newington, Connecticut 06111 • 860.667.4453
45 Meriden Avenue • Southington, Connecticut 06489 • 860.621.9559

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 Ileo 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 _____

Relationship _____

Signature of person completing application