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 __________________________
Realtionship ___________________________ __________________________________________ Signature of person completing application