Application for Long Term Admission

*SCM Staff used only_____
□ Date received: _____
□ Date follow up: _____
□ Date of admission: _____

South Cove Manor at Quincy Point
Rehabilitation Center
中華頤養院康復中心

288 Washington Street, Quincy, MA 02169 Tel: 617-423-0590 Fax: 617-237-3021

Name of Applicant:	MEDICARE#
DOB: Sex: Male/ Female	MEDICAID/MASSHEALTH#
ADDRESS:	SOCIAL SECURITY #
	UNITED HEALTH #
CONTACT PERSON:	SENIOR WHOLE HEALTH #
RELATION TO APPLICANT:	OTHER INSURANCE AND POLICY #:
PHONE:	HEALTH CARE PROXY AGENT:

*THE SECOND PART BELOW MUST COMPLETE BY DOCTOR OR NURSE.

PRIMARY PHYSICIAN:	PCP PHONE:
DIAGNOSIS:	MEDICATIONS:

BEHAVIOR	YES	NO
ALERT		
ORIENT PERSON		
ORIENT PLACE		
ORIENT TIME		
CONFUSED		
NOISY		
WANDERS		
COMBATIVE		
OTHER		

MOBILITY	INDEPEND	ASSIST	DEPENDANT
AMBULATE			
WHEELCHAIR			
OTHER			

ADLS	INDEPEND	ASSIST	DEPENDANT
BATHE			
GROOM			
DRESS			
EATING			

Weight Weight Change

SKIN CONDITION

DECUBITIS:

TREATMENTS/ PROCEDURES:

INFECTION YES/NO

INFECTION STATUS:

ISOLATION YES/NO

PPD Result + -- DATE:

PNEUMO VAC RECEIVED: Yes/ No

FLU VAC RECEIVED: Yes/ No

TD: Yes/ No

TOILET	CONTINENT	INCONTINENT
BLADDER		
BOWEL		

OTHER NEEDS:	YES	NO
DIALYSIS		
O_2 THERAPY		
C PAP		
OSTOMY CARE		

G-TUBE FEEDING:

G-TUBE FORMULAR:

Chest X-Ray RESULT:

DATE RECEIVED:

DATE RECEIVED:

DATE RECEIVED:

*PLEASE SUBMITED THIS FORM WITH	COMMENT:
□ Copy of insurance cards front and back	
□ Lastest Medication list □ Medical Record	