

# PRE-ADMISSION INQUIRY RECORD

PROSPECT'S NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY, STATE, ZIP \_\_\_\_\_

DATE OF INQUIRY \_\_\_\_\_  
 AGE \_\_\_\_\_ SEX:  M  F  
 DATE OF BIRTH \_\_\_\_\_  
 HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  
 MARITAL STATUS: M S D W SEP  
 LANGUAGES \_\_\_\_\_  
 RELIGION \_\_\_\_\_  
 SOC. SECURITY NO. \_\_\_\_\_  
 MEDICARE NO. \_\_\_\_\_  
 MEDICAID NO. \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_

|                         |                   |
|-------------------------|-------------------|
| IF ACCEPTED             |                   |
| DESIRED ADMISSION DATE: | ASSIGNED ROOM NO. |

REFERRING AGENCY OR PERSON INQUIRING \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY, STATE, ZIP \_\_\_\_\_

PHONE \_\_\_\_\_  
 PHONE \_\_\_\_\_

CASE WORKER \_\_\_\_\_  
 PATIENT PRESENTLY AT \_\_\_\_\_ UNIT \_\_\_\_\_  
 ATTENDING PHYSICIAN \_\_\_\_\_  
 PRIMARY DIAGNOSIS \_\_\_\_\_

PHONE \_\_\_\_\_  
 PHONE \_\_\_\_\_

## PRELIMINARY MEDICAL INFORMATION

| — LOCOMOTION     | YES   | NO    | — ADL SKILLS     | YES   | NO    | — MENTAL STATUS             | YES   | NO    |
|------------------|-------|-------|------------------|-------|-------|-----------------------------|-------|-------|
| FULLY AMBULATORY | _____ | _____ | SELF CARE        | _____ | _____ | ALERT                       | _____ | _____ |
| WHEELCHAIR       | _____ | _____ | ASSISTANCE       | _____ | _____ | WANDERS                     | _____ | _____ |
| WALKER           | _____ | _____ | TOTAL CARE       | _____ | _____ | NOISY                       | _____ | _____ |
| CRUTCHES         | _____ | _____ | — BATH           |       |       | COMBATIVE                   | _____ | _____ |
| CANE             | _____ | _____ | WITH ASSISTANCE  | _____ | _____ | CONFUSED                    | _____ | _____ |
| BED              | _____ | _____ | TUB              | _____ | _____ | — SLEEP HABITS              |       |       |
| — DISABILITIES   |       |       | SHOWER           | _____ | _____ | FULL NIGHT                  | _____ | _____ |
| PARALYSIS        | _____ | _____ | — DRESS          |       |       | INTERVAL                    | _____ | _____ |
| WHERE _____      |       |       | WITH ASSISTANCE  | _____ | _____ | WALKS IN SLEEP              | _____ | _____ |
| VISION           | _____ | _____ | — FEEDING        |       |       | — DENTURES                  | _____ | _____ |
| HEARING          | _____ | _____ | WITH ASSISTANCE  | _____ | _____ | — HEARING AID               | _____ | _____ |
| CARDIAC          | _____ | _____ | TUBE FEEDING     | _____ | _____ | — GLASSES                   | _____ | _____ |
| — DECUBITI       |       |       | — DIABETIC       |       |       | Podiatrist _____            |       |       |
| WHERE _____      |       |       | MEDICATION _____ |       |       | Ambulance _____             |       |       |
| DRAINAGE         | _____ | _____ | — ALLERGIES      |       |       | Insurance Information _____ |       |       |
| DRESSINGS        | _____ | _____ | WHAT KIND _____  |       |       | _____                       |       |       |
| KIND _____       |       |       | — THERAPIES      |       |       | _____                       |       |       |
| — CONTROLS       |       |       | OCCUPATIONAL     | _____ | _____ | — OXYGEN REQUIRED           | _____ | _____ |
| BOWELS           | _____ | _____ | PHYSICAL         | _____ | _____ |                             |       |       |
| BLADDER          | _____ | _____ | SPEECH           | _____ | _____ |                             |       |       |
| CATHETER         | _____ | _____ |                  |       |       |                             |       |       |

CURRENT MEDICATIONS AND TREATMENT \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Have advanced directive been executed? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DIET REQUIREMENTS \_\_\_\_\_  
 TYPE OF RESIDENT:  PRIVATE  MEDICARE <sup>A</sup> \_\_\_\_\_  MEDICAID \_\_\_\_\_  OTHER \_\_\_\_\_  
EFFECTIVE DATE EFFECTIVE DATE EFFECTIVE DATE

LEVEL OF CARE \_\_\_\_\_  
 PROSPECT'S ATTITUDE TOWARD PLACEMENT:  AGREED  UNDECIDED  NEGATIVE

**Financial and Benefit Screening Form**

**Financial Information**

Has the Resident/Representative applied, or will the Resident/Representative be applying soon for State Medical Assistance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Medical Assistance/Medicaid #: \_\_\_\_\_

Share of Cost/Patient Liability Amount Per Month \$ \_\_\_\_\_

If the Resident/Legal representative has applied, what was the date: \_\_\_\_\_

County: \_\_\_\_\_

DSHS Representative: \_\_\_\_\_ Phone #: \_\_\_\_\_

Comments or additional information: \_\_\_\_\_

**Prior Hospitalization:** Transferring Hospital: \_\_\_\_\_

**Hospitalization Dates:** From: \_\_\_\_\_ to \_\_\_\_\_

**Hospital SNF Dates:** From: \_\_\_\_\_ to \_\_\_\_\_

**Supplemental and/or long-term care insurance that will cover nursing care:**

Insurance Co.: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_

**Complete attached Benefit Screening Form**

Social Security \_\_\_\_\_/(month) Civil Service Retirement \_\_\_\_\_/(month)

VA Pension \_\_\_\_\_/(month) Military Retirement \_\_\_\_\_/(month)

Railroad Pension \_\_\_\_\_/(month) Rental Income \_\_\_\_\_/(month)

Annuities \_\_\_\_\_/(month) Investments/Other \_\_\_\_\_/(month)

**Real Estates Assets**

Resident own home? \_\_\_\_\_ Yes \_\_\_\_\_ No Approx. Value: \_\_\_\_\_

Property owned? \_\_\_\_\_ Yes \_\_\_\_\_ Individually Name of Co-owner: \_\_\_\_\_

Does Resident own any additional property: \_\_\_\_\_ Yes \_\_\_\_\_ No Value: \_\_\_\_\_

**Life Insurance**

Any policies with cash value? \_\_\_\_\_ Yes \_\_\_\_\_ No Approx. Value: \_\_\_\_\_

**Other Assets/Investments (stocks, bonds, IRAs)** \_\_\_\_\_

**Attachment F- Page 2 of 2**

**Cash Assets in banks, credit unions, savings and financial institutions**

Institution Name: \_\_\_\_\_ Location: \_\_\_\_\_

Balance in Account: \_\_\_\_\_ Name on Account: \_\_\_\_\_

Institution Name: \_\_\_\_\_ Location: \_\_\_\_\_

Balance in Account: \_\_\_\_\_ Name on Account: \_\_\_\_\_

Institution Name: \_\_\_\_\_ Location: \_\_\_\_\_

Balance in Account: \_\_\_\_\_ Name on Account: \_\_\_\_\_

Information Source: \_\_\_\_\_

Person completing financial screening: \_\_\_\_\_ Date: \_\_\_\_\_

**General Benefit Information:**

**Medicare Supplemental/Medi-Gap, LTC Insurance Employee Group Medical Plans**

Resident Name: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_

ID or Policy Number: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Type of Plan: \_\_\_\_\_

Medicare Coinsurance: \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_ /day

Coverage after 100<sup>th</sup> day: \_\_\_\_\_ Yes \_\_\_\_\_ No Amount of Coverage: \$ \_\_\_\_\_ /day

Medicare Part B coverage? \_\_\_\_\_ Yes \_\_\_\_\_ No Notes: \_\_\_\_\_

\_\_\_\_\_ Deductible: \$ \_\_\_\_\_ /year Met? \_\_\_\_\_ Yes \_\_\_\_\_ No

Pre-authorization necessary? \_\_\_\_\_ Yes \_\_\_\_\_ No Notes: \_\_\_\_\_

**Billing Information**

Assignment Accepted? \_\_\_\_\_ Yes \_\_\_\_\_ No Notes: \_\_\_\_\_

Billing forms Needed: \_\_\_\_\_ UB-92 \_\_\_\_\_ Medicare EOB Other: \_\_\_\_\_

Name of insurance verifier: \_\_\_\_\_ Date: \_\_\_\_\_