The John Clarke Retirement & Nursing Center
600 Valley Road
Middletown, RI 02842-7094

(401) 846-0743 Business Office
(401) 848-5890 FAX

APPLICATION FOR ADMISSION TO THE NURSING CENTER

Date of Application: _______________

Person assisting with this application:________________________________ Phone: __________________________

APPLICANT INFORMATION

NAME:		NICKNAME:
ADDRESS:		PHONE:
APPLICANT'S CURRENT LOCATION (e.g.: home, hospital, etc):		
SOCIAL SECURITY #:	US CITIZEN? (circle) YES NO	
DATE OF BIRTH:	BIRTHPLACE:	PRIMARY LANGUAGE:
RELIGION:	CHURCH/ SYNAGOGUE:	
EDUCATION:	LIFETIME OCCUPATION:	
MARITAL STATUS: SINGLE MARRIED ____________ (date) DIVORCED ________ (date) WIDOWED ___________ (date) SEPARATED_____ (date)		

APPLICANT IS SEEKING: ☐ LONG TERM PLACEMENT ☐ SHORT TERM PLACEMENT (REHAB)	
WHEN ARE YOU LOOKING FOR PLACEMENT?	
REASON ADMISSION IS REQUESTED:	
Applicant's attitude toward placement:	
Family's attitude toward placement:	
Previous experience in group living/ when:	
Current home care agencies involved with applicant (if any):	
PHYSICIAN'S NAME:	PHYSICIAN'S PHONE:

DAILY ROUTINES/ INDIVIDUAL NEEDS

Please circle the answer that best describes applicant's abilities.

WALKING	independent	needs some assistance	unable	comment:
EATING	independent	needs some assistance	unable	comment:
PERSONAL HYGEINE	independent	needs some assistance	unable	comment:
DRESSING	independent	needs some assistance	unable	comment:
BATHING	independent	needs some assistance	unable	comment:
BATHROOM	independent	needs some assistance	unable	comment:

CONTINENT OF BLADDER? YES or NO

CONTINENT OF BOWEL? YES or NO

ALCOHOL USE: YES or NO

HEIGHT: WEIGHT:

DOES THE APPLICANT SMOKE? YES NO

(JCRC IS A SMOKE FREE FACILITY. RESIDENTS WHO SMOKE MAY DO SO OUTDOORS IN DESIGNATED AREAS)

PLEASE DESCRIBE APPLICANT'S USUAL SLEEPING PATTERN:

SPECIAL INTERESTS/ SKILLS AND ARE THESE STILL PURSUED?:

PLEASE DESCRIBE APPLICANT'S COMMUNICATION STYLE:

PLEASE DESCRIBE APPLICANT'S CURRENT ABILTITY TO RECALL: SHORT TERM : LONG TERM :

APPLICANT'S FOOD PREFERENCES:

MEDICAL / HEALTH INFORMATION

WILL THE APPLICANT'S PHYSICIAN BE FOLLOWING THEM IN THIS FACILITY? (circle) YES NO

IF YES, PHYSICIAN'S NAME:

PLEASE DESCRIBE APPLICANT'S CURRENT MEDICAL CONDITION :

APPLICANT'S MOST RECENT HOSPITALIZATION(S):

IS APPLICANT ON A SPECIAL DIET? IF SO, PLEASE DESCRIBE:

DOES APPLICANT HAVE ANY ALLERGIES? IF SO, PLEASE LIST:

DOES THE APPLICANT USE THE FOLLOWING?: (please circle) eyeglasses hearing aids partials or dentures cane walker wheelchair oxygen special utensils : ________________________

IS THE APPLICANT FOLLOWED BY ANY OF THE FOLLOWING SPECIALISTS? (PLEASE INCLUDE NAMES)
DENTIST:
PODIATRIST:
OPTHAMOLOGIST/ OPTOMETRIST:
DERMATOLOGIST:
CARDIOLOGIST:
SOCIAL WORKER/ PSYCHIATRIST/ PSYCHOLOGIST:
PHARMACY:

Please note that JCRC has in-house services available for eye, dental and podiatry care. Applicants may, however, choose to continue with these services in the community. While JCRC is able to provide occasional transportation family are ultimately responsible for ensuring transportation for such appointments. JCRC also utilizes a pharmacy that delivers to our home. If you choose to continue with your current pharmacy, family will be responsible for medication delivery to the facility.

WHICH JCRC SERVICES WILL THE RESIDENT BE USING? (please circle)

DENTIST PODIATRIST EYE CARE PHARMACY

SPOUSE/ SIGNIFICANT OTHER INFORMATION

SPOUSE'S FULL NAME:	
ADDRESS:	
HOME PHONE:	WORK :

EMERGENCY CONTACTS

We regularly inform our residents' responsible party, next of kin, or significant other of any changes in the resident's status or plan of care. Please list, in order, which people should be contacted with such information. It is important to list at least two people in case the primary contact person cannot be reached. We will go down the list until we reach someone to inform of the changes.

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE
1.			
2.			
3.			

FINANCIAL INFORMATION	
SOCIAL SECURITY #	**MEDICARE #**
MEDICAID #	**VETERAN CLAIM #** (if known/applicable)
BLUE CROSS/BLUE SHIELD #	**STATE:**
OTHER INSURANCE #	
DOES APPLICANT HAVE RIPAE FOR PRESCRIPTIONS? YES NO	

RESPONSIBLE PARTY INFORMATION	
NAME:	
ADDRESS:	
HOME PHONE:	WORK PHONE:
RELATIONSHIP TO APPLICANT:	
GUARDIAN:	
POWER OF ATTORNEY FOR HEALTH CARE DECISIONS:	
FOR FINANCIAL DECISIONS:	
DOES APPLICANT HAVE A LIVING WILL?	
PLEASE NOTE: If any of the above applies, please furnish JCRC a copy of the document for our records upon admission (it is not necessary to provide these with this application)	

I SWEAR THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUTHFUL
AND HAS BEEN COMPLETED TO THE BEST OF MY ABILITY.

SIGNATURE____ DATE : _______________
(APPLICANT OR RESPONSIBLE PARTY)

RELATIONSHIP TO APPLICANT: ____

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REPORT OF EXAMINATION OF APPLICANT BY PHYSICIAN

(TO BE COMPLETED BY THE APPLICANT'S PHYSICIAN)

APPLICANT'S NAME:		ALLERGIES:
CURRENT DIAGNOSES:		
PROGNOSIS, POTENTIAL FOR REHAB:		
SIGNIFICANT MEDICAL HISTORY:		
MEDICATIONS AND TREATMENTS:		**DNR STATUS:**
DIET AND TEXTURE:		
RECENT LAB RESULTS:		
RECENT X-RAY RESULTS:		
VISION:		HEARING:
SKIN CONDITIONS:		SKIN TREATMENTS:
E.N.T.:	THYROID:	LUNGS:
CHEST:	B/P:	HEART:
ABDOMEN:	PELVIS:	NEURO:
LEGS:	FEET:	CONTINENCE:
AMBULATION:	ASSISTIVE DEVICES:	WT BEARING?
HEIGHT:	WEIGHT:	COGNITIVE STATUS:
EXTREMITIES: ROM:		EDEMA:

Will you follow this patient after nursing home admission? YES ________ NO ___________

Physician's Name ________________________________ Signature ____________________________________

Phone: ____ Date: ____