EMERGENCY ROOM/HOSPITAL ADMITTANCE FORM

Form to be completed by residential staff prior to bringing the individual with mental retardation to the Emergency Room or admitting the individual to the hospital.

Date: _____ Completed by: _____ Relationship to Individual: _____

Name: _____ Nickname/Likes to be called: _____

DOB: _____ Soc Sec #: _____

Address: _____

_____

Phone #: _____

Health Insurance (Type & Numbers)

Primary: _____

Secondary: _____

Allergies: _____

Living Status: Group Home____ Family Living____ Lives Independently _____ Other_____

Nursing Supports Available at provider agency? (circle) Yes or No; RN and/or LPN Name: _____

Emergency Contacts

Name (Provider Agency):_____
Phone Number: _____
Phone Number (After Hours): _____

Name (Family): _____
Relationship: _____
Phone Number: _____

County Contact Person: _____
Phone Number: _____
Phone Number (After Hours): _____

Primary Care Physician: _____
Phone Number: _____

Reason for ER visit today:

Neurologist: _____
Phone Number: _____

Current Medical Problems/Diagnoses:

Psychiatrist: _____
Phone Number: _____

Level of Mental Retardation (circle one):
Mild Moderate Severe Profound

Consent Status:

- ❑ CAN give own consent
- ❑ CANNOT give own consent. Has a Legal Guardian.
  Legal Guardian: _____ Phone Number: _____
- ❑ CANNOT give own consent. Does not have a Legal Guardian. Has a Substitute Healthcare Decision Maker.
  Name: _____ Phone Number: _____
  Medical Durable POA: _____ Phone Number: _____

Resuscitation Status:

- ❑ DNR****
- ❑ Full Resuscitation

If DNR, List Reason: _____ Date DNR Given: _____ By Whom: _____

Consent for Release of Information to Provider(circle one): Yes No

Date of Last Tetanus: _____ Date of Last PPD: _____ Date of Last Flue Shot: _____
Date of Last Pneumovax: _____ Date of Hepatitis B Vaccines: _____

the Advocacy Alliance

Communication
□ Able to Communicate
□ Communication Difficulties/Uses verbalizations
□ Communication Difficulties/Uses gestures
□ Not able to communicate needs
□ Unable to use call bell

Vision:
□ Normal
□ Low Vision
□ Blind
□ Wears glasses
□ Wears contact lenses

Hearing:
□ Normal
□ Hard of Hearing (Left/Right)
□ Deaf (Left/Right)
□ Hearing Aid (Left/Right)

Supportive Devices:
□ Padded side rails
□ Splints
□ Braces
□ Helmut
□ Other _____

Toileting Ability:
□ Continent
□ Needs Assistance
□ Incontinent
□ Catheterized
□ Other_____

Medication Administration:
□ Independent/Self Medicates
□ Medication Administered by Staff

Dining/Eating
□ Independent
□ Needs Assistance
□ Totally Dependent
□ Fed Through a Tube
□ Other _____

Diet Texture
□ Regular
□ Chopped
□ Ground
□ Puree
□ Thickened Liquid

Diet Type_____
Last Meal Eaten _____

Ambulation:
□ Independent □ Steady □ Unsteady
□ Needs Assistance □ 1 Person □ 2 Person
□ Walker □ Cane □ Crutches
□ Wheelchair □ Non-Ambulatory

Personal Hygiene
□ Independent
□ Special Needs _____

Oral Hygiene
□ Independent
□ Special Needs _____
□ Dentures (Upper/Lower/Partial)

Head of Bed Elevated (Yes/No)

SPECIAL NEEDS

Usual Response to Medical Exams: □ Cooperates □ Partially Cooperates □ Resistant/Becomes Agitated □ Fearful/Anxious

□ Any sedation required for clinical visits_____
□ Special positioning required for examination _____
□ Staff required for assistance with exams _____
□ Requires limited waiting periods for exams
□ Prefers early day appointments □ Prefers end of day appointments
□ Special communication device/method _____

Pain Response: □ Normal □ Unique _____

Medical History: □ Known □ Unknown
For information, contact: _____ Relationship _____
Phone _____ Address_____

SURGICAL

List all previous surgeries and dates (most recent first):
_____
_____
_____

Any previous problems with anesthesia:
□ No □ Yes _____

List any serious trauma or broken bones:
_____
_____

MEDICAL

List all serious medical illnesses (e.g. pneumonia, heart attack) and ongoing medical problems (e.g. diabetes, high blood pressure, epilepsy) _____
_____
_____

PSYCHIATRIC

List all major behavioral and psychiatric diagnoses (e.g. depression, schizophrenia, self-injurious behavior)
_____

WOMEN'S HEALTH

Currently Pregnant: □ Yes □ No
Past History of Childbirth □ Yes □ No
Age menstruation started_____
Age menstruation stopped _____
□ Still menstruating
Date of Last PAP_____
History of Abnormal PAP?
□ Yes □ No _____
Date of Last Mammogram _____

MEN'S HEALTH

Date of Last Prostate Exam_____
Date of PSA_____
□ Normal □ Abnormal N/A