



Keiro Intermediate Care Facility
 325 South Boyle Avenue
 Los Angeles, CA 90033-3812
 (323) 263-9655
 (323) 263-2721-fax

Office Use Only

Date Received	
Admission Date	
Admission #	
Room #	
Status	PVT / HMO / MCL
From	

Pre-Admission Application

General Information						
Name (Last, First, MI)		Age	Date of Birth	Gender	*Marital Status	Religion
					"N" for never married	
Birthplace (City, State/Prefecture, Country)			Citizenship		Resident of CA since	
Naturalization # (if applicable)		Date	Alien Registration # (if applicable)		Date	
Where is the applicant currently residing?(Home or Name of Facility; include address/zip code)					Phone Number	
Social Security #		Medicare #	Medicare Part D Drug Plan		Medi-Cal # (if applicable)	
Private Insurance Name: Policy #:			Applicant's source of income <input type="checkbox"/> Social Security <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Other ()			
Primary Physician		Address (include zip code)			Phone # Fax # Pager	
Dentist		Address (include zip code)			Phone #	
Mortuary/Funeral Home		Address (include zip code)			Phone #	
Primary Language		2 nd Language (if applicable)		*English Speaking Ability <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Former Occupation			Room Preference: <input type="checkbox"/> Private Room <input type="checkbox"/> Semi-Private <input type="checkbox"/> First Available			
Family Members: Please list in order of emergency contact						
Responsible Party / 1 st contact		Relationship	Address (include zip code)			Phone # (Home) (Work) (Cell)
E-mail:						
Name / 2 nd contact		Relationship	Address (include zip code)			Phone # (Home) (Work) (Cell)
E-mail:						
Name / 3 rd contact		Relationship	Address (include zip code)			Phone # (Home) (Work) (Cell)
E-mail:						
Name / 4 th contact		Relationship	Address (include zip code)			Phone # (Home) (Work) (Cell)
E-mail:						

Medical Information			
Dental: <input type="checkbox"/> Own teeth <input type="checkbox"/> Full denture(s) (Upper / Lower) <input type="checkbox"/> Partial denture(s) (Upper / Lower) <input type="checkbox"/> Implant		Vision: <input type="checkbox"/> No deficit <input type="checkbox"/> Wears eyeglasses <input type="checkbox"/> Eyeglasses for reading only <input type="checkbox"/> Blind (Right / Left)	
		Hearing: <input type="checkbox"/> No deficit <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Hearing aid (Both / Right / Left) <input type="checkbox"/> Deaf (Right / Left)	
Please complete the information below by placing a \checkmark in the appropriate box			
	Independent	Needs Some Assistance	Needs Total Assistance
Ambulation / Ability to walk		<input type="checkbox"/> Uses cane <input type="checkbox"/> Uses walker	<input type="checkbox"/> Uses wheelchair
Dressing			
Eating			
Toileting			
Bathing			
Personal Hygiene			
Urine: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent		Bowel Movement: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent	
	Friendly	Stubborn	Physically Aggressive
	Outgoing	Complains (chronically)	Verbally Aggressive
	Inactive	Obsessive (hoards)	Poor Appetite
	Isolationist	Demanding	Weight loss (in past 3 months)
	Forgetful	Repetitive	Difficulty sleeping
	Confused/Disoriented	Depressed	Chronic Constipation
	Wandering	Anxious	History of smoking / drinking
Vaccine History	<input type="checkbox"/> Influenza Vaccine Date:	<input type="checkbox"/> Pneumonia Vaccine Date:	<input type="checkbox"/> Shingles Vaccine Date:
Tuberculosis (TB) History	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, when was applicant treated?)	
Fall History (any falls in past 6 months)			
Hospitalization History (include Emergency visits)			
Surgical History (cataract, glaucoma etc.)			
Any pain? (back pain, knee pain etc.)			
Any allergies? (medication, food etc.)			
Psychiatric History	Applicant has been treated by <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Any other counseling		
	Psychotherapeutic medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Since when?
	Reason for treatment:		
*Marital Status	<input type="checkbox"/> Married, if so when & where?		
	<input type="checkbox"/> Divorced, if so when?		
	<input type="checkbox"/> Widowed, if so when did spouse expire?		
Person completing application		Relationship	Date
Please provide a copy of insurance cards & list of current medications.			

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