Keiro Senior HealthCare

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 "N" for never married	Religion
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 ☐ Social Security ☐ Supplemental Security Income ☐ 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	2nd Language (if applicable)	*English Speaking Ability ☐ Excellent ☐ Good ☐ Fair ☐ Poor			
Former Occupation		Room Preference: ☐ Private Room ☐ Semi-Private ☐ First Available			

Family Members: ***Please list in order of emergency contact***			
Responsible Party / **1st contact** E-mail:	Relationship	Address (include zip code)	Phone # (Home) (Work) (Cell)
Name / **2nd contact** E-mail:	Relationship	Address (include zip code)	Phone # (Home) (Work) (Cell)
Name / **3rd contact** E-mail:	Relationship	Address (include zip code)	Phone # (Home) (Work) (Cell)
Name / **4th contact** E-mail:	Relationship	Address (include zip code)	Phone # (Home) (Work) (Cell)

Medical Information		
Dental: ☐ Own teeth ☐ Full denture(s) (Upper / Lower) ☐ Partial denture(s) (Upper / Lower) ☐ Implant	Vision: ☐ No deficit ☐ Wears eyeglasses ☐ Eyeglasses for reading only ☐ Blind (Right / Left)	Hearing: ☐ No deficit ☐ Hard of hearing ☐ Hearing aid (Both / Right / Left) ☐ Deaf (Right / Left)

Please complete the information below by placing a √ in the appropriate box

	Independent	Needs Some Assistance	Needs Total Assistance
Ambulation / Ability to walk		☐ Uses cane ☐ Uses walker	☐ Uses wheelchair
Dressing			
Eating			
Toileting			
Bathing			
Personal Hygiene			
Urine: ☐ Continent ☐ Incontinent		Bowel Movement: ☐ Continent ☐ 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	☐ Influenza Vaccine	☐ Pneumonia Vaccine	☐ Shingles Vaccine
	Date:	Date:	Date:

Tuberculosis (TB) History	☐ Yes ☐ 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 ☐ Psychiatrist ☐ Psychologist ☐ Any other counseling	
	Psychotherapeutic medications? ☐ Yes ☐ No	Since when?
	Reason for treatment:	

∗Marital Status	☐ Married, if so when & where?
	☐ Divorced, if so when?
	☐ Widowed, if so when did spouse expire?

Person completing application	Relationship	Date

Please provide a copy of insurance cards & list of current medications.