

**SOUTH BAY KEIRO NURSING HOME**

15115 S. Vermont Ave.  
Gardena, CA 90247  
Phone # : (310) 532-0700  
Fax # : (310) 532-0001

**KEIRO NURSING HOME**

2221 Lincoln Park Ave.  
Los Angeles, CA 90031  
Phone # : (323) 276-5700  
Fax # : (323) 276-5732

**PRE-ADMISSION APPLICATION**

Date Received:
Admission Date:
Admission # :
Room # :
Status: PVT MCR MCL HMO
Transferred Fr:
By:

**GENERAL INFORMATION:**

Name (Last, First, MI)	Age	Birthdate	Sex M F	Marital Status	Religion:
"N" for never married					
Where is the applicant currently residing? (circle one) Home Hospital Nursing Home Other:					
Home/Last Permanent Address or Name of Facility:		Address:	City:	State:	Zip:
Birthplace: City, State/Prefecture, Country		US Citizen? <input type="checkbox"/> Y <input type="checkbox"/> N		Phone: ( )	
Naturalization # (if applicable)		Date	Alien Registration # (if applicable)		Date
<b>Please provide a copy of insurance cards</b>					
Social Security #	Medicare #	Medicare Part D Drug Plan	Medi-Cal #	(Indicate if Pending) [ ] Yes [ ] No	
Private Insurance / HMO/ Secondary Insurance (Name & Policy #)		Applicant's source of income: <input type="checkbox"/> Soc. Sec. <input type="checkbox"/> SSI <input type="checkbox"/> Other _____			
Responsible Party / Guarantor		Relationship	Home#		
			Work#		
Address: City: State: Zip:			Cell#		
			Email:		
Employed By:	Address:	City:	State:	Zip:	

**FAMILY MEMBERS: Please list in order of emergency contact.**

Name / <b>Emergency &amp; First Contact</b>	Relation:	Address:	City:	State:	Zip:	Home#	
						Work#	Cell#
						Email:	
Name / <b>2nd Contact</b>	Relation:	Address:	City:	State:	Zip:	Home#	
						Work#	Cell#
						Email:	
Name / <b>3rd Contact</b>	Relation:	Address:	City:	State:	Zip:	Home#	
						Work#	Cell#
						Email:	
Name / <b>4th Contact</b>	Relation:	Address:	City:	State:	Zip:	Home#	
						Work#	Cell#
						Email:	

Place of Worship:	Phone #	<b>Mortuary/Funeral Home:</b>	Phone #
Address: ( )	( )	Address:	( )
Admitting Physician	Address:	City:	State: Zip: Phone #
Dentist	Address:	City:	State: Zip: Phone #

**BACKGROUND INFORMATION:**
**Generation:**  Issei  Nisei  Kibei-nisei  Sansei

Primary Language	2nd Language (if applicable)	Previous Occupation
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Hobbies/Interests

**Advance Directive: If "Yes", please check one of the following and provide a copy of the document for the Medical Record.**

- Yes  Advance Health Care Directive/Durable Power of Attorney for Health Care  Preferred Intensity of Care  
 No  Natural Death Act Initiative  Living Will  Other: \_\_\_\_\_

**MEDICAL INFORMATION:**

Admit From:	City:	State:	Zip:	Phone # (    )
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Admitting Diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Hospital:</b>	<b>Address:</b>	<b>Phone#</b>
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Has applicant received psychiatric treatment/counseling?  
 Yes    No   If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Behavioral Patterns:	Yes	At Times	No		Yes	At Times	No
Adaptive/Flexible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable/Demanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Isolationist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complains (chronically)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lethargic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disoriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive (hoards)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Defensive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stubborn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibitionist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dentures: <input type="checkbox"/> Y <input type="checkbox"/> N	Visual Impairment: <input type="checkbox"/> Y <input type="checkbox"/> N	Hearing Impairment: <input type="checkbox"/> Y <input type="checkbox"/> N
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**Nursing Care Needs/Requirements: (Please check the appropriate spaces.)**

Ambulation/Ability to Walk <input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance Uses: _____ (cane, walker, etc.) <input type="checkbox"/> Complete bed care / uses wheelchair	Dressing <input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Needs total assistance	Eating <input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance Other: _____	Hygiene <input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Needs Total Assistance
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Please list any medications the applicant is currently taking: \_\_\_\_\_  
 \_\_\_\_\_

Allergies: (If none, please indicate)	Continent: Urine - <input type="checkbox"/> Y <input type="checkbox"/> N            BM - <input type="checkbox"/> Y <input type="checkbox"/> N
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Medical problems or remarks: \_\_\_\_\_  
 \_\_\_\_\_

Reason for Admission: \_\_\_\_\_  
 \_\_\_\_\_

Person completing application	Relationship	Date
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