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

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

Office Use Only

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

PRE-ADMISSION APPLICATION

GENERAL INFORMATION:

Name (Last, First, MI)	Age	Birthdate	Sex M F	Marital Status "N" for never married	Religion:

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:	Phone: ( )

Birthplace: City, State/Prefecture, Country	US Citizen? ☐ Y ☐ N	Resident of CA since:

Naturalization # (if applicable)	Date	Alien Registration # (if applicable)	Date

Please provide a copy of insurance cards

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: ☐ Soc. Sec. ☐ SSI ☐ 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	Relation:	Address: City: State: Zip:	Phone
Name / **Emergency & First Contact**	Relation:	Address: City: State: Zip:	Home# Work# Cell# Email:
Name / **2nd Contact**	Relation:	Address: City: State: Zip:	Home# Work# Cell# Email:
Name / **3rd Contact**	Relation:	Address: City: State: Zip:	Home# Work# Cell# Email:
Name / 4**th Contact**	Relation:	Address: City: State: Zip:	Home# Work# Cell# Email:

Place of Worship: Address:	Phone # ( )	**Mortuary/Funeral Home:** Address:	Phone # ( )
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

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 # ( )

Admitting Diagnosis: ______________________________

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____

Hospital:	**Address:**	**Phone#**

Has applicant received psychiatric treatment/counseling?

☐ Yes ☐ No If yes, please explain: ______________________________

____

Behavioral Patterns:

	Yes	At Times	No		Yes	At Times	No
Adaptive/Flexible	☐	☐	☐	Irritable/Demanding	☐	☐	☐
Aggressive	☐	☐	☐	Isolationist	☐	☐	☐
Complains (chronically)	☐	☐	☐	Lethargic	☐	☐	☐
Confused	☐	☐	☐	Mood Swings	☐	☐	☐
Disoriented	☐	☐	☐	Obsessive (hoards)	☐	☐	☐
Depressed	☐	☐	☐	Repetitive	☐	☐	☐
Defensive	☐	☐	☐	Stubborn	☐	☐	☐
Exhibitionist	☐	☐	☐	Violent	☐	☐	☐
Forgetful	☐	☐	☐	Wanders	☐	☐	☐
Inactive	☐	☐	☐	Withdrawn	☐	☐	☐

Dentures: ☐ Y ☐ N	Visual Impairment: ☐ Y ☐ N	Hearing Impairment: ☐ Y ☐ N

Nursing Care Needs/Requirements: ***(Please check the appropriate spaces.)***

Ambulation/Ability to Walk	Dressing	Eating	Hygiene
☐ Independent	☐ Independent	☐ Independent	☐ Independent
☐ Needs Assistance	☐ Needs Assistance	☐ Needs Assistance	☐ Needs Assistance
Uses: ____________________ (cane, walker, etc.)	☐ Needs total assistance	Other: ________________	☐ Needs Total Assistance
☐ Complete bed care / uses wheelchair			

Please list any medications the applicant is currently taking: ______________________________

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Allergies: (If none, please indicate)	Continent: Urine - ☐ Y ☐ N BM - ☐ Y ☐ N

Medical problems or remarks:

Reason for Admission:

Person completing application	Relationship	Date