



NORTHWOODS

Dignified Nursing Alternatives

Resident Application

Thank you for your interest in Dignity & Grace/Brookside/Hillcrest/Touch of Home.

We strive to provide the personal, high quality care and living environment that we, ourselves, would want our parents and grandparents to experience.

This application is designed to help us best assess your needs. If you have any questions, please don't hesitate to call and let us be of assistance. There will likely be many spaces you won't have filled in- That's okay! We can help you find the needed information.

Thank you for the opportunity to serve you.

Sincerely,
Ron and Melanie Burns

Brookside
2729 State 371 NW
Pine River, MN 56474
218-587-3304

Dignity and Grace
823 State 371 NW
Backus, MN 56435
218-947-4445

Hillcrest
607 2nd Street S.
Walker, MN 56484
218-547-4445

Touch of Home
711 17th St NW
Bemidji, MN 56601
218-444-2775

Touch of Home
21st St NW
Bemidji, MN 56601
218-444-5878

Resident Application

Name: _____ Date: _____
 Last **First** **Middle** **Preferred**

Address: _____

County: _____

Present Living Arrangements:

___ Alone in house/apartment
___ With _____ in house/ apartment
___ Assisted living: _____
___ Nursing Home: _____
___ Other: _____

Date of Birth: _____ Birth Place: _____

Marital Status: ___ Married ___ Divorced ___ Never Married ___ Widowed

Spouse's name: _____ If living, where is spouse: _____

Children and Other Important Contacts:

Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____ (home) _____ (cell)

Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____ (home) _____ (cell)

Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____ (home) _____ (cell)

Number of children: _____ Do you have any pet allergies: _____

Level of education completed: _____

Former occupations: _____

Religious preference/church membership: _____

Pastor: _____ Would you like church/pastor notified: _____

If out of town: address, phone number, or website of church: _____

Physician: _____ Clinic: _____

Other medical specialists:

Name	Specialty	Clinic name/ City	Phone Number
	Dentist		
	Eye doctor		

Preferred Hospital:

___ Brainerd ___ Staples ___ Crosby ___ Park Rapids ___ Bemidji ___ Other: _____

Advanced Directives: (Check all that apply, and please provide copies for our files)

___ Do not resuscitate

___ Do not intubate

___ Health care directive

___ Mental health directive

We have forms and resources available to help you with the above documents if you wish to create them.

____ Healthcare power(s) of attorney: _____

____ Financial power(s) of attorney: _____

Mortuary: (Regulations require that we have the name of the mortuary to be called in case of death)

Name: _____ City: _____

Pre-paid funeral arrangements: ____ Yes ____ No

Social Security # _____ - _____ - _____ Medical Assistance # _____
Effective Date: _____

Medicare #: _____ VA Claim #: _____

Part A-Hospital Effective Date: _____ Dates of Services: _____ to _____

Part B-Medical Effective Date: _____

Are you or your spouse a wartime vet? ____ Yes ____ No

(If yes, you may be eligible for VA benefits. Call Cass County Veterans Services at 218-547-1340)

Do you receive State/County Assistance: ____ Yes ____ No

Name of Case Worker: _____

If applying for Medical Assistance: Date Applied: _____

Financial Worker: _____ County: _____

Do you have any other insurance: ____ Yes ____ No

Insurance Company: _____

Phone Number: _____ Fax Number: _____

Effective Date: _____

** Please provide copies of your MA, insurance and Social Security Cards*

Current Pharmacy:

Name: _____ City/State: _____

Will the pharmacy deliver to Dignity & Grace/Brookside/Hillcrest: ____ Yes ____ No

If No will you pick up prescriptions: _____

Phone: _____

Fax: _____

Business mail should be sent to (Name and address)

Medical Conditions: _____

Surgical History: _____

History of:

Alcohol Abuse: ____ Yes ____ No

Drug Abuse: ____ Yes ____ No

Smoking: ____ Yes ____ No

Currently smokes: ____ Yes ____ No

If yes how much: _____ If quit how long ago: _____

Psychiatric Illness: ____ Yes ____ No

If known, what type: _____

Current Medications

Name of Drug	Dosage	Frequency	Time Taken

Drug Allergies:

Type of Reaction:

Ambulation:

___ Walks unassisted ___ Needs Assistance ___ Cane ___ Walker ___ Wheelchair

History of falls: ___ Yes ___ No

When: _____ How Often: _____ Related to: _____

Mental Condition:

___ Alert/oriented ___ Alert/oriented but forgetful ___ Disoriented

Speech: Preferred language if other than English: _____

Bowel Elimination:

Continent Incontinent Uses pads Frequency: _____
 Constipation difficulties Uses laxatives Enema

Urinary Elimination:

Continent Incontinent Uses pads Frequency: _____

Hearing: Wears hearing aide: Yes No Which ear: Left Right

Vision: Wears glasses Contact lenses Cataracts Glaucoma

Description of Glasses: _____ Marked for ID: _____

Skin: Open areas Yes No If yes, where: _____

Describe any skin conditions: _____

Dentures: Upper Lower Partial Marked for ID: _____

Orthotics/Prosthetics: _____

Valuables

We request that you secure all valuables for safekeeping prior to admission.

Thank you!

Current Abilities

Check areas that accurately describe applicant at this time	Occurs frequently (weekly?)	Occurs occasionally	Rarely or never occurs
Orientation			
Unaware of day or date			
Doesn't know home is where they live			
Wandering or getting lost			
Trouble remembering events			
Communication			
Unable to write			
Unable to read			
Unable to communicate needs clearly			
Experiences difficulty finding words			
Unable to understand simple directions			
Unable to understand any directions at this time			
Ambulation			
Loss of balance, or falling when walking			
Unusual gait(shuffling, leaning, fast pacing)			
Has difficulty sitting in a chair			
Bumps into things (Walls, furniture)			

Activities of Daily Living

Please use 1, 2, or 3 to indicate level of dependence

1 = Independent

2 = Needs some assistance

3 = Totally dependent

<p>Ability to feed self <i>Helpful ways to assist:</i> _____ _____ <i>Adaptive devices needed:</i> _____ _____</p>	1	2	3	<p>Ability to do dental care <i>Helpful ways to assist:</i> _____ _____ _____</p>	1	2	3
<p>Ability to dress self <i>Helpful ways to assist:</i> _____ _____ _____ <i>Need for special clothing:</i> _____ _____ _____</p>				<p>Ability to toilet self <i>Helpful ways to assist:</i> _____ _____ <i>Is incontinent of bowel</i> ___ Always ___ Sometimes ___ Never <i>Is incontinent of bladder</i> ___ Always ___ Sometimes ___ Never <i>Concerns: (loose stools, constipation, etc.)</i> _____ _____</p>			
<p>Ability to shave self ___ Razor ___ Electric razor <i>Helpful ways to assist:</i> _____ _____</p>				<p>Ability to use make-up <i>Still likes to use:</i> ___ Yes ___ No <i>Helpful ways to assist:</i> _____ _____</p>			
<p>Ability to bathe self <i>Prefers:</i> ___ Bath ___ Shower <i>Time of day:</i> _____ <i>Frequency:</i> _____ per week <i>Helpful ways to assist:</i> _____ _____</p>				<p>Ability to wash own hair <i>Washes:</i> ___ in shower ___ in sink ___ at beauty shop ___ other <i>Helpful ways to assist:</i> _____ _____</p>			

Sleep patterns:

Sleeps through the night: ___ yes ___ no

Frequently awakes at night: ___ yes ___ no

Sleeps during the day: _____ Nap times: _____

Usual time to rise: _____

Usual time to retire: _____

Sleep-related concerns: _____

Helpful ways to assist: _____

Dietary Preferences

Dietary	Yes	No	Sometimes	Time of Day
Do you: Eat breakfast?				
Eat lunch?				
Eat dinner?				
Snack?				
Are you able to: Feed yourself? Use regular utensils?				

Food dislikes/intolerances: _____

Food allergies: _____

Foods that help relieve constipation: _____

Foods that help relieve loose stools: _____

Favorite foods: _____

Have you had a significant weight loss in the past 3 months? _____ How much? _____

Have you had a significant weight gain in the past 3 months? _____ How much? _____

Pain Assessment

Please note any pain or discomfort you experience on a regular basis due to a physical condition (headaches, joint pain, etc.): _____

How do you usually acknowledge/communicate this pain? _____

What usually relieves your pain/discomfort? _____

Activity

What type of leisure activities have you enjoyed in the past? _____

What type of leisure activities do you still enjoy now? _____

Moods and Behaviors

Please check appropriate column.

	Regularly occurs	Occasionally occurs	Never or very rarely occurs
Wandering			
Continuous Pacing			
Repetitive Behaviors (words, actions)			
Withdrawn, depressed (long periods of inactive time)			
Appears anxious, worried			

Crying, tearful			
Under eating			
Overeating			
Clinging (to caregiver, can't leave side)			
Verbally abusive (curses, swears, threatens)			
Physically abusive (strikes out at caregiver)			
Rummaging or hoarding (goes through things or collects things)			
Inappropriate toileting habits			
Inappropriate sexual behavior			
Sun-downing behavior (difficult behaviors or increased confusion occur in late afternoon)			
Hallucinations (hears or sees things that are not there)			
Delusions (tells anxious stories that are not fact-based)			
Suspiciousness			
Resistant to care			
Overreacts to stressful situations			
Sleep disturbances			
Mood swings			

When you are upset, what is the best way to comfort you? ___ humor ___ snack
 ___ affection ___going for a walk ___ leave you alone ___ other _____

Are there situations that upset you? ___ car rides ___ being alone
 ___ being touched ___ unfamiliar surroundings ___ demands (personal care)
 ___ other: _____

Behavior-related concerns/comments: _____

Signature of resident or representative

Relationship

Date