

ROTARY ANN HOME, INC
Email address: rah@goldfieldaccess.net

Phone 515-448-5124
Fax 515-448-5167

ADMISSION INFORMATION
For Rotary Ann Nursing Home and Rotary Ann Retirement Home

Our business office is located at 620 SE 5th St. Eagle Grove, IA 50533.
Office hours are from 8:00 a.m. to 4:00 p.m. Mon.-Fri.

We admit, Monday thru Friday, 9:00 am thru 3:00 pm, unless other arrangements are made with the business office and nursing department. **A physical must be completed BEFORE admission.** This must be with the **local clinic, Trimark Physicians Group, phone 515-448-5185.** Let the clinic know that the physical is for admission to one of our facilities, Retirement or Nursing.

This ADMISSION INFORMATION form must be completed and returned to the business office, BEFORE admission.

Admitting to: **Nursing** or **Retirement**

Date of admission: _____ What time: _____

NAME: First _____ Middle _____ Last _____ Preferred Name _____

(spouse's first name for mail sorting reference _____)

Birth date _____ Age Marital Status _____ never _____
M W D S-married Social Security # _____

Medicare # _____ Medicaid # _____ VA # _____

Home address _____ City _____ St _____ Zip _____ County _____

Payment Source? Private T19 Other Admitted from Hosp/Home _____
Referred by: _____ Hosp or Home(address) _____

Supplemental Health Insurance _____ ID # _____ Policy# _____
Address & Phone # _____

Nursing Home Insurance _____ ID # _____ Policy # _____
Address & Phone # _____

List all known Allergies _____

IMMUNIZATIONS---We **MUST** have these 4 questions answered.

Has the resident had the pneumonia shot? _____ If **no** what is the reason? _____

What is the date of the last flu shot? _____ If resident has not received why? _____

Lifetime Occupation? _____ Highest year of education? _____

The 1st Emergency Contact **MUST** also be the Heathcare POA (Durable POA)

1st Emergency Contact _____ Phone #s _____ Cell# _____
Address _____ Home _____ Work# _____
Relationship _____

2st Emergency Contact _____ Phone #s _____ Cell# _____
Address _____ Home _____ Work# _____
Relationship _____

Other Contacts _____ Phone#s _____ Cell# _____
Address _____ Home _____ Work# _____
Relationship _____

We will need copies of any papers such as Powers of Attorneys, Living Wills or Healthcare POA papers.

Also bring your Medicare, Social Security, and Insurance cards, and we will make copies.

Financial POA _____ Phone # _____
Address _____

Healthcare POA _____ Phone # _____
Address _____

Religion _____ Clergy _____ Phone # _____
Church Name _____
Address _____ Phone # _____

Will the resident bring a TV for his/her room. _____ (cable cost is \$10 month)
Will the resident have a telephone in his/her room Y N If yes phone # if you know it. _____

All doctor, dentist, eye doctor & pharmacy must be local---some have been filled out.

Physician

Physician: fill in the doctors name → Name: _____
Clinic----→ 448-5185 Clinic: Trimark Physician Group

Optometrist: 448-3813 Dr. Gazaway Eagle Grove IA

Dentist Phone # _____ Name _____
Address _____

(circle one)

Podiatrist Choices are Dr. Hartman, 574-6880 Fort Dodge or Dr. Judy Reinking, 295-9644, Algona

Pharmacy: 448-3814 Eagle Pharmacy Eagle Grove IA

Hospital Preference (if you have one) _____

Mortuary Phone#: _____ Mortuary _____
Mortuary Address _____

ADVANCE DIRECTIVES:

Do You have a **Living Will:** Yes _____ No _____

If you want a DNR or a DNH, it will be arranged with the physician.

DNR (Do Not Resuscitate) Yes, arrange this _____ No _____ not at this time

DNH (Do Not Hospitalize) Yes, arrange this _____ No _____ not at this time

Organ Donation: Yes _____ No _____

Body Donation: Yes _____ No _____

Any other information _____

The bill should be sent to: _____

Mailing Address _____

Do you want bills sorted from personal mail and the bills forwarded to the above address? _____