Taft Home Residential Care
1337 SW Washington St / Portland, OR 97205
Tel: 503.223.2144 / Fax: 503.241.9553

APPLICATION FOR ADMISSION

(To be completed by applicant, family or case worker)

Applicant's Preferred Name: _____D.O.B. ____ / ____ / ____

Gender Identity: Female ____ / Male ____ Preferred Pronoun:_____Relationship Status: _____

Current Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Phone #: _____ - _____ - _____ Medicaid #:_____

Medicare #: _____ VA #: _____

Referring Case Worker: _____ Phone #: _____ - _____ - _____

Medical Diagnosis: _____

Psychiatric Diagnosis: _____

Health Insurance: _____ Policy: _____

Financial Responsibility: _____ Phone #: _____ - _____ - _____

Source(s) of Income: _____ Monthly Amount: $_____

In Case of Emergency:

Name: _____ Relationship: _____

Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Name: _____ Relationship: _____

Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Primary Care Physician's Name: _____ Phone #: _____ - _____ - _____

Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Dentist's Name: _____ Phone #: _____ - _____ - _____

Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Psychiatrist's Name: _____ Phone #: _____ - _____ - _____

Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Hospital: _____ Phone #: _____ - _____ - _____

Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Means of Transportation to Appointments: _____

Religion: _____ Church: _____ Phone #: _____ - _____ - _____

Funeral Home: _____ Phone #: _____ - _____ - _____

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MEDICAL SURVEY AND HEALTH HISTORY

(To be completed by Primary Care Physician)

Applicant's Name: _____ D.O.B. ____ / ____ / ____

Current Address: _____
Street Address / Apt # or Ste # / City / State / Zip

D.O.B. ____ / ____ / ____ ll Hgt: ____' ____" ll Wgt: _____ # ll BP ____ / ____ ll P: ____ ll R: ____

PCP's Name: _____ Phone #: _____ - _____ - _____

Address: _____
Street Address / Apt # or Ste # / City / State / Zip

Medical Diagnosis

Primary: _____

Secondary: _____

Psychiatric Diagnosis

_____

Ambulatory Status

Independent _____ ll Cane _____ ll Walker _____ ll Electric Scooter _____

Other (please provide details): _____

Drug and/or Alcohol Use

Does applicant have a **history** of using / abusing drugs and/or alcohol? Yes _____ No _____

Is applicant **actively** using / abusing drugs or alchohol? Yes _____ No _____

If not actively using, how long clean and sober? _____

If applicant has history of using / abusing and / or actively using / abusing, please provide details:

_____

_____

Continence Status

Incontinent of: Bowel: Y ____ / N ____ ll Bladder: Y ____ / N ____
If Yes to either, please provide the extent of the condition:

_____

Violent Tendencies

Does applicant have a **history** of violence? Yes _____ No _____

If yes, please provide details, including any criminal charges or other interventions that were required:

_____

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MEDICAL SURVEY AND HEALTH HISTORY

(To be completed by Primary Care Physician)

Suicidal Tendencies

Does applicant have a **history** of suicidality? Yes _____ No _____

If yes, please provide details, including any hospitalizations or other interventions that were required:
_____

Medication Administration

Is applicant capable of administering his / her own medications? Yes _____ No _____

Known Allergies: _____

TB Status

A TB test and/or chest x-ray is required of all applicants, and must be completed within 30 days prior to admission to Taft.

Date of TB Test: ____ / ____ / ____ Results: Positive _____ Negative _____

If **POSITIVE**, please provide results of chest x-ray: Date of x-ray: ____ / ____ / ____

Findings: _____

_____

Current Nursing Treatments

_____
_____
_____

Diet

General _____ No Added Salt _____ No Added Sugar

Other dietary restrictions or requirements: _____

Diabetic Status

Is applicant diabetic? Yes _____ No _____ Any known family history of diabetes? Yes _____ No _____
If applicant is diabetic, please give details of current treatment:

_____
_____

Other Comments

_____
_____
_____

~ PLEASE ATTACH A COPY OF PHYSICIAN'S HISTORY AND PHYSICAL EXAM OF APPLICANT ~