MISSOURI VETERANS COMMISSION
MISSOURI VETERANS HOME

# ADMISSION MEDICAL INFORMATION

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| VETERAN NAME | | DATE |
|---|---|---|
| INDIVIDUAL PROVIDING INFORMATION | RELATIONSHIP TO VETERAN | TELEPHONE |

## SELF-CARE STATUS (CHECK LEVEL OF ASSISTANCE NEEDED)

| | NO HELP NEEDED | NEEDS SUPERVISION | A LITTLE ASSISTANCE | A LOT OF ASSISTANCE | TOTAL ASSISTANCE |
|---|---|---|---|---|---|
| Can the applicant feed him/herself? | | | | | |
| Can the applicant dress him/herself? | | | | | |
| Can the applicant bathe him/herself? | | | | | |
| Can the applicant transfer him/herself? | | | | | |
| Does the applicant walk? | | | | | |

## SELF-CARE STATUS (CHECK APPROPRIATE ANSWER)

| | | YES | NO |
|---|---|---|---|
| EATING | Any difficulty chewing or swallowing? | ☐ | ☐ |
| | IF YES, DESCRIBE | | |
| | In the last 3 months, has there been a decline in the ability to feed self? | ☐ | ☐ |
| | COMMENTS | | |
| | PLEASE LIST SPECIAL DIET ORDERS | | |
| | PLEASE LIST ANY FOOD ALLERGIES | | |
| WEIGHT | Any changes in weight in past month? | ☐ | ☐ |
| | Any changes in weight in past 6 months? | ☐ | ☐ |
| | IF YES, DESCRIBE | | |
| | USUAL ADULT BODY WEIGHT (AVERAGE WEIGHT OVER PAST 2 YEARS) | | |
| DRESSING | In the last 3 months, has there been a decline in the ability to dress self? | ☐ | ☐ |
| | COMMENTS | | |
| WALKING | Does the applicant need assistance? If so, how much? | ☐ | ☐ |
| | Does the applicant use any of the following (check one): ☐ cane, ☐ walker, ☐ wheelchair, ☐ gerichair? | ☐ | ☐ |
| | In the past month, has the applicant fallen? | ☐ | ☐ |
| | In the past 6 months, has the applicant fallen? | ☐ | ☐ |
| | COMMENTS | | |
| BOWEL/BLADDER | Is the applicant able to control bladder? | ☐ | ☐ |
| | Does the applicant use a urinary catheter? | ☐ | ☐ |
| | Does the applicant have a history of urinary tract infections? | ☐ | ☐ |
| | Has the applicant been hospitalized or treated for urinary tract infections in the past 6 months? | ☐ | ☐ |
| | IF YES, WHEN? | | |
| | In the past 3 months, has there been a decline in ability to control bladder? | ☐ | ☐ |
| | Is the applicant able to control bowels? | ☐ | ☐ |
| | Does the applicant have a history of constipation? | ☐ | ☐ |
| MENTAL | Is the applicant confused? | ☐ | ☐ |
| | Does the applicant wander? | ☐ | ☐ |
| | Is the applicant combative? | ☐ | ☐ |
| | In the past 3 months, has there been a decline in memory and/or decision making? | ☐ | ☐ |
| | COMMENTS | | |
| | Any sleeping problems? | ☐ | ☐ |
| | IF YES, DESCRIBE | | |
| | In the past 3 months, has there been a decline in mood and/or behavior? | ☐ | ☐ |
| | IF YES, DESCRIBE | | |

| SELF-CARE STATUS (CHECK APPROPRIATE ANSWER) | | YES | NO |
|---|---|---|---|
| COMMUNICATION ABILITY | Can speak | ☐ | ☐ |
| | Can write | ☐ | ☐ |
| | Understands speaking | ☐ | ☐ |
| | Understands writing | ☐ | ☐ |
| | Understands gestures | ☐ | ☐ |
| | Understands English | ☐ | ☐ |
| | If no, state language spoken: | | |
| | Does the applicant have any difficulties with speech? | ☐ | ☐ |
| | Does the applicant have any difficulties with hearing? | ☐ | ☐ |
| | Does the applicant have any difficulties with eyesight? | ☐ | ☐ |
| | In the past 3 months, has there been a decline in ability to express him/herself, understand or hear? | ☐ | ☐ |
| | COMMENTS | | |
| Does the applicant have any skin breakdowns or bed sores? | | ☐ | ☐ |
| OXYGEN | Does the applicant use oxygen? | ☐ | ☐ |
| | IF YES, DESCRIBE HOW OFTEN? | | |
| | HOW MANY LITERS OF OXYGEN NEEDED? | | |
| | Any respiratory treatments? | ☐ | ☐ |
| | IF YES, DESCRIBE | | |
| Does the applicant have pain daily? | | ☐ | ☐ |
| IF YES, DESCRIBE PAIN AND TREATMENTS | | | |
| Has there been any new diagnosis since the initial application? | | ☐ | ☐ |
| IF YES, DESCRIBE | | | |
| In the past 3 months, has the applicant been hospitalized? | | ☐ | ☐ |
| IF YES, WHERE | | | |
| In the past 3 months, has the applicant been seen in the ER? | | ☐ | ☐ |
| IF YES, WHERE | | | |
| Any visits to psychologist, psychiatrist, or social worker? | | ☐ | ☐ |
| IF YES, SEEN BY WHOM, WHEN, WHERE? | | | |
| HISTORY | **Resident history 5 years prior to entry** | ☐ | ☐ |
| | Prior stay at this nursing home? | ☐ | ☐ |
| | Stay in other nursing home? | ☐ | ☐ |
| | Other residential facility (board and care home, assisted living, group home, etc.) | ☐ | ☐ |
| | Mental health/psychiatric setting? | ☐ | ☐ |
| | Mentally retarded/developmentally disabled? | ☐ | ☐ |
| | None of the above | ☐ | ☐ |

In the year prior to date of entry to this nursing home, or year last in community if now being admitted from another nursing home, does the applicant (check appropriate answer):

| CYCLE OF DAILY EVENTS | YES | NO |
|---|---|---|
| Stay up late at night (after 9 p.m.)? | ☐ | ☐ |
| Nap regularly during day (at least 1 hour)? | ☐ | ☐ |
| Go out 1 or more days a week? | ☐ | ☐ |
| Stay busy with hobbies, reading or fixed daily routine? | ☐ | ☐ |
| Spend most of time alone or watching TV? | ☐ | ☐ |
| Move independently indoors (with assistive devices, if used)? | ☐ | ☐ |
| Use tobacco products, at least daily? | ☐ | ☐ |

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| EATING PATTERNS | YES | NO |
|---|---|---|
| Distinct food preference? | ☐ | ☐ |
| Eats between meals? | ☐ | ☐ |
| Uses alcoholic beverages at least weekly? | ☐ | ☐ |
| **ACTIVITIES OF DAILY LIVING** | **YES** | **NO** |
| In bedclothes much of the day? | ☐ | ☐ |
| Wakens to toilet all or most nights? | ☐ | ☐ |
| Has irregular bowel movement pattern? | ☐ | ☐ |
| Prefers showers for bathing? | ☐ | ☐ |
| Bathe in the p.m.? | ☐ | ☐ |
| Bathe in the a.m.? | ☐ | ☐ |
| **INVOLVEMENT PATTERNS** | **YES** | **NO** |
| Daily contact with relatives/close friends? | ☐ | ☐ |
| Usually attends church, temple, synagogue, etc.? | ☐ | ☐ |
| Finds strength in faith? | ☐ | ☐ |
| Daily animal companion/presence? | ☐ | ☐ |
| Involved in group activities? | ☐ | ☐ |

IS THERE ANY OTHER INFORMATION CONCERNING THE APPLICANT THAT WOULD BE HELPFUL?

NAME OF APPLICANT

SIGNATURE

DATE