





Dear Applicant;

Enclosed is the admission application that you requested for our facility. Please complete and return the first section of the application in order to be placed on our waiting list. Returning the application does not obligate the applicant in any way to become a resident of our facility. It will be kept on file and in the event that the type of room that you have requested becomes available a member of our administrative staff will contact you. Again, at this time you are not obligated to accept the room being offered. If you do not wish to proceed at that time and decline the bed offer but wish to remain on our waiting list for the future availability we will contact you the next time a similar room becomes available.

In order for the application to be reviewed and/or approved, it must be completed in its entirety. If something on the application does not apply to you, please write “N/A” in the space. Please do not leave any blank spaces. The application cannot be processed if any space is left blank.

The second section of the application must be filled out by the applicant’s primary care physician (or the attending MD if in a hospital or skilled nursing facility). Please do not complete any part of the medical section. Once a decision has been made to proceed with the admission process the primary MD or physician currently following the potential resident must complete all parts of this section after a full examination of the potential resident. The MD exam, completion of paperwork and admission to facility must all occur within 30 days of each other. If it is completed more than 30 days prior to admission, it will have to be completed again so appointments for completion of paperwork should be made in coordination with our facility. Our policy is that all residents are tested for Tuberculosis (PPD test) within 30 days prior to admission. Paperwork is included for primary MD use.

Please submit a copy of all insurance cards and advance directives with the application to the business office.

For questions or to schedule a tour of our home; please feel free to contact our facility at (518) 762-5488 Monday-Friday 9am-4pm. The following is a directory of our Administrative staff:

Kara Vollmer – RN, Administrator – Extension 101 or kvollmer1@hotmail.com

Amy Ouellette – Financial Manager – Extension 106 or pineviewcommonsalf@gmail.com

Bernadine Buseck- Administrative Assistant- Extension 110 or bernadinebuseck@yahoo.com

We look forward to meeting you.

Sincerely,

Kara Vollmer, RN

Administrator/Operator

**PINEVIEW COMMONS HOME FOR ADULTS**

**PRE-ADMISSION QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete

**Do you wear glasses ?** Yes \_\_\_\_ No \_\_\_\_ Only for Reading \_\_\_\_

**Do you have dentures?** Yes \_\_\_\_ No \_\_\_\_

 Partials \_\_\_\_ Full \_\_\_\_ Upper Plate Only \_\_\_\_ Lower Plate Only \_\_\_\_

**Do you wearing hearing aids?** Yes\_\_\_\_ No \_\_\_\_

 Both Ears \_\_\_\_ Left Ear Only \_\_\_\_ Right Ear Only \_\_\_\_

**Do you use a device to assist you with walking?**  Yes \_\_\_\_ No \_\_\_\_

 Walker \_\_\_\_ Cane \_\_\_\_ A wheelchair for long distances? Yes \_\_\_\_ No \_\_\_\_

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IMPORTANT**

**Please make sure all clothing is marked upon admission.**

**Please submit a copy of all insurance cards with this application.**

**Please submit a copy of all advance directives with this application.**

**APPLICATION FOR ADMISSION TO**

**PINEVIEW COMMONS ASSISTED LIVING**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby make application for admission to Pineview Commons LLC, located at 201 South Melcher Street, Johnstown, New York 12095.

**PLEASE FILL IN ALL INFORMATION** - (PLEASE PRINT)

**PERSONAL INFORMATION**

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Country County

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Present Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My occupation has been: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am a member of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ church.

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pastor/Rabbi: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Hobbies and Interests are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Marital Status is: (PLEASE CIRCLE ONE) Single Married Widowed Divorced

**FINANCIAL INFORMATION**

I understand the basic private pay rates for all services offered in the admission agreement are: (ALL RATES BELOW ARE MONTHLY RATES)

$**2,400.00 for a semi-private room.**

**$2,700.00 for a private room.**

**$3,100.00, $3,300.00, $3,500.00, $4,500.00 – large private/suite**

**$5,500.00, $6,000.00 for a suite (TWO PERSON OCCUPANCY).**

**$8,000.00 (DOUBLE ROOM SUITE - TWO PERSON OCCUPANCY).**

I expect to be able to pay this private rate for \_\_\_\_\_\_\_\_ years. (Please Estimate).

I am the owner of the following property:

1. Real Estate: (Describe and List Value) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Car: (Describe and List Value) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Stocks/Bonds: (Describe and List Value) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If I should exhaust my private funds and apply for assistance, (S.S.I.), I understand the S.S.I assistance rate paid to the Adult Home is a Room and Board rate and is below the Home’s private rate. I further understand the Home will not accept this S.S.I. rate without a third party contributor supplementing the Home up to the Home’s private rate.**

**THIRD PARTY CONTRIBUTOR’S INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Applicant: \_\_\_\_\_\_\_\_\_\_

I will have my relative (s) or representative take care of my financial affairs while I am at Pineview Commons LLC.

**REPRESENTATIVE’S/EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Applicant: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*ADDITIONAL FAMILY CONTACTS - IF REPRESENTATIVE ABOVE CANNOT BE REACHED.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Phone Relation to Applicant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Phone Relation to Applicant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Phone Relation to Applicant

**MEDICAL INFORMATION**

Resident’s Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital of Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County of Medicaid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Health Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Physicians:**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL ASSISTANCE INFORMATION**

I understand this is an **ADULT CARE FACILITY** providing room and board with laundry and housekeeping services. There will be adequate staff to assist me with personal care services such as: personal hygiene, medication management, and functions of daily living. A recreation and social program will be provided. There will be personal care staff available to me on a 24-hour basis.

**Options for transportation to medical appointments**

 1. Family will take and/or make arrangements

 2. Pineview Commons to arrange/provide transportation.

We need to know how you would like us to handle doctor appointment transportation. Pineview Commons can provide this transportation at an additional cost unless Medicaid is in effect.

**\_\_\_Pineview Commons \_\_\_Family Transportation**

I will be needing assistance with personal care services as listed below:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I am admitted to the Home, I request that my personal mail be given to me and that my business mail be handled by \_\_\_me, or \_\_\_my representative. (Please check one)

Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESIDENT’S REPRESENTATIVE INFORMATION**

I understand if the resident should require a higher level of care due to physical or mental impairment, it will be my responsibility to make arrangements for the proper placement and transfer.

This will be done by me, after proper evaluation, assistance, and notice by the Home.

Resident Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT PINEVIEW COMMONS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*AFTER COMPLETING PLEASE REVIEW ENTIRE APPLICATION TO BE SURE IT IS COMPLETED IN FULL\*\*\***

****

**RESOURCES - BANK ACCOUNTS, CD’S**

Name of Bank and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Savings: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Checking: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has authority to deposit and withdraw from these accounts--:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REAL ESTATE**

Do you own any real estate: \_\_\_\_\_ If so, appraised value: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any assets held by other parties? \_\_\_\_\_ If so, please describe: \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Power of Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PINEVIEW COMMONS HOME FOR ADULTS - ALP**

**ADVANCE DIRECTIVE INFORMATION**

**\*\*This form to be completed with the Application for Admission.**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BURIAL ARRANGEMENTS**

Funeral Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADVANCE DIRECTIVES**

**(health care proxy, DNR, living will, etc.)**

Please list what directives have been obtained.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POWER OF ATTORNEY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*The facility must have copies of all documents listed above\*\*

**THE FOLLOWING IS THE MEDICAL PAPERWORK**

This paperwork goes with the applicant to the doctor’s appointment. To be completed by physician and submitted to Pineview Commons for review before admission can proceed.

Do not use this document – form no longer in use

|  |
| --- |
| Check all that apply: \_X\_ AH \_\_EHP \_\_ALP \_\_Initial \_\_RUG Category Change \_\_12 Month |

DSS-4449-C1 (rev. 4/97)

|  |  |  |
| --- | --- | --- |
|  |  | Name: |
| This form may be used to verify that an individual's health/safety needs can appropriately be met in an adult home, enriched housing program or residence for adults. It may also be used to verify that an applicant/resident of an Assisted Living Program (ALP) is medically eligible to reside in a nursing facility but does not require continual nursing or skilled care and the individual's needs can be met in an ALP. |
| Facility Name:Pineview Commons LLC |
| Address:201 South Melcher StreetJohnstown, NY 12095 |  |
| Sex Date of Birth M( ) F( ) / / | Weight B/P  |

Primary Diagnosis:

Secondary Diagnosis:

|  |  |  |
| --- | --- | --- |
| Significant medical history and current conditions: do not use this form – old document | Continence: Bladder: \_\_Yes Bowel: \_\_Yes | \_\_No \_\_No |
| Diet: **Regular, CAT** **NAS, CAT** **Consistent Carbohydrate, CAT** |
| Needs assistance with self-administration of meds? \_X\_Yes \_\_ No | Allergies: |

List ail current medications (prescription and OTC), including dosage, type, frequency, and method of administration, and note any special instructions:(attach additional sheet if necessary).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MEDICATION | DOSAGE | TYPE | FREQUENCY | METHOD |
|  |  |  |  |  |
|  |  |  |  |  |
| DO NOT USE THIS FORM – OLD DOCUMENT |  |  |  |  |
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Revised 3/99

DSS-4449-C2 (Rev. 4/97)

MEDICAL EVALUATION *(page 2)*

 Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Individual:

Free of communicable disease? \_\_Yes \_\_ No If no describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Able to transfer without Assistance? \_\_Yes \_\_No If no, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ambulatory without assistance? \_\_Yes \_\_No If no, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe Activity Restrictions/Assistance Needed with ADLs (e.g., eating, transferring, toileting):

DO NOT USE THIS FORM – OLD DOCUMENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the individual have a history, current condition or recent or current hospitalization for mental disability?

\_\_Yes \_\_No If yes describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is a Mental Health Evaluation recommended? \_\_Yes \_\_No

Date of Today's Examination: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Recommended Frequency of Medical Exams: As ordered by MD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared in an Adult Home enriched housing program or an ALP

Signature: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nurse Practitioner, Physician's or Specialist Assistant*

Signature: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Physician (required)*

Revised 3/99

**ATTACHMENT TO MEDICAL EVALUATION**

**STANDING/PRN ORDERS - OVER THE COUNTER MEDICATIONS**

**Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Acetaminophen 325 mg**

 - 2 tablets po every 4-6 hours as needed (not to exceed more than 12 tablets in 24 hours)

 May be used for relief of Headache, Minor aches and pains, Minor Arthritis Pain,

 For the reduction of Fever

**Maalox (or generic equivalent)**

 - 10-20 ml po up to 4 times daily (not to exceed 80 ml in a 24 hour period)

 May be used for the relief of: Upset Stomach/Indigestion

**Milk of Magnesia (or generic equivalent)**

 - 5-15 ml po with water up to 4 times daily - Not to exceed more than 60 ml in 24 hours)

 May be used as a Laxative to relieve constipation

**Imodium AD tablets (or generic equivalent)**

- 2 tablets po after the first loose stool; 1 caplet after each subsequent loose stool

 - Not to exceed more than 4 tablets in 24 hours

**Imodium AD Liquid (or generic equivalent)**

 - 20 ml po after the first loose stool; 10 ml after each subsequent loose stool

 - Not to exceed 40 ml in 24 hours

**Robitussin DM (or generic equivalent)**  Regular \_\_\_\_\_\_ Sugar Free\_\_\_\_\_ (check one)

 - 10 ml po every four hours - Not to exceed 60 ml in 24 hours

 To be used to relieve cough and to help loosen secretions

**Cough Drops**  Regular \_\_\_\_\_\_ Sugar Free \_\_\_\_\_ (check one)

 - 1 drop dissolved in mouth for minor cough - Repeat every 2 hours as needed

\*Physician Signature verifies order and that resident is capable of requesting any of the above.

Physician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Pineview Commons Home for Adults*

*Record of TB Screening*

*\*\*\*Must be completed in full\*\*\**

**Per New York State Department of Health Regulations, (NYS DOH), all residents must be screened for TB before being admitted into the Adult Home. One or Two Step Tuberculin Skin Tests, (TST) are acceptable to the NYS DOH. Please note that NYS DOH does prefer the Two Step TST. However: The decision to use the One or Two Step TST is up to each individual physician.**

***Resident***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Physician***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date PPD Given: \_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot # \_\_\_\_\_\_\_\_ Site:\_\_\_\_\_\_\_

Given by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Read by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results of Test: Negative \_\_\_\_\_ Positive \_\_\_\_\_ Induration (mm): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF POSITIVE: Date of CXR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*If date of first TST is negative do you want a second TST? Yes \_\_\_\_\_ No \_\_\_\_\_**

\*\*\*\*\*Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\* If applicable - Submit copy of written CXR report.

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**Date of 2nd TST – IF APPLICABLE**

Given: \_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot # \_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_

Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Read by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results of Test: Negative \_\_\_\_\_ Positive \_\_\_\_\_ Induration (mm): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

***Pineview Commons Home for Adults***

***Record of Vaccinations/Influenza/Tetanus/Pneumonia***

***\*\*\*Must be completed in full\*\*\****

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your patient received:

 1. A tetanus shot - in the past five years? Yes\_\_\_\_ No\_\_\_\_

 If yes: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Pneumonia Vaccination: Yes\_\_\_\_ No\_\_\_\_

 If yes: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*\*If no, do you want facility to arrange for administration of vaccine Yes \_\_\_\_ No \_\_\_\_***

 3. Influenza Vaccination: Yes\_\_\_\_ No\_\_\_\_

 If yes: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*\*If no, do you want facility to arrange for administration of vaccine Yes \_\_\_\_ No \_\_\_\_***

MD Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Pineview Commons Home for Adults

201 South Melcher Street

Johnstown, NY 12095

762-5488

Fax# 762-5583

**PRIMARY MD AUTHORIZATION FOR PODIATRY CARE**

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Lam, DPM comes to the facility on a scheduled basis to provide podiatry care for the residents.

Please verify below with signature that your patient may see Dr. Lam for an initial consult, every 2-3 months, and PRN for one of the reasons listed below.

**PLEASE CHECK ONE OR MORE OF THESE**

**\_\_\_\_\_\_\_DIABETES MELLITIS**

**\_\_\_\_\_\_\_PVD**

**\_\_\_\_\_\_\_NEUROPATHY**

**\_\_\_\_\_\_\_FUNGAL NAILS**

**\_\_\_\_\_\_\_INGROWN NAILS**

**\_\_\_\_\_\_\_THICK MYCOTIC NAILS**

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PINEVIEW COMMONS HOME FOR ADULTS

201 SOUTH MELCHER STREET

JOHNSTOWN, NEW YORK 12095

518-762-5488

FAX 762-5583

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK ONE OF THE FOLLOWING AND VERIFY WITH YOUR SIGNATURE BELOW THAT YOU WISH TO BE NOTIFIED ON A

**DAILY BASIS\_\_\_\_\_\_\_\_\_\_\_**

 **WEEKLY BASIS\_\_\_\_\_\_\_\_\_\_\_**

 **MONTHLY BASIS\_\_\_\_\_\_\_\_\_\_\_**

 **NOT AT ALL\_\_\_\_\_\_\_\_\_\_\_**

OF ANY MEDICATION REFUSALS BY THE ABOVE MENTIONED RESIDENT

WHO RESIDES AT PINEVIEW COMMONS.

MD COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***\*\*\*IF MONTHLY NOTIFICATION IS REQUESTED IT WILL BE SENT TO YOU AT THE BEGINNING OF THE FOLLOWING MONTH.***

Physician's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH EVALUATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FACILITY: PINEVIEW COMMONS HOME FOR ADULTS**

**SIGNIFICANT MENTAL HEALTH HISTORY AND CURRENT CONDITION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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 **Date discharged to: PINEVIEW COMMONS HOME FOR ADULTS from:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Name of Facility/Hospital)**

I have completed this evaluation in the presence of the above named within the past thirty (30) days, and I find him/her mentally suited for the care provided at PINEVIEW COMMONS HOME FOR ADULTS. This person does not show evident need for placement in a residential treatment facility licensed or operated pursuant to article nineteen, twenty-three, twenty-nine, or thirty-one of the mental hygiene law.

MD SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TITLE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK ONE:

 \_\_\_\_\_\_PREADMISSION EVALUATION

 \_\_\_\_\_\_ANNUAL EVALUATION

 \_\_\_\_\_\_HOSPITAL DISCHARGE EVALUATION-(Mental Health Admit)

 \_\_\_\_\_\_ER EVALUATION

State of New York

Department of Health

Non hospital Order Not to Resuscitate

(DNR Order)

Person’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Do not resuscitate the person named above.

Physician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person’s medical chart. The issuance of a new form is **NOT** required, and under the law this order should be considered valid if it has not been reviewed within the 90 day period.

PCHFA