Maple Woods Assisted Living and Memory Care
33310 State Hwy 6 Deer River, MN 56636
Phone (218) 999-9072 Fax (218) 999-9068
Email: mwoods@paulbunyan.net

Confidential Placement Resident Application:

Date:_____

Name _____
Last First (legal) Middle preferred

Address_____

Phone_____
County_____

Date of Birth: _____

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

Emergency and family contact name, address, and phone number: List 1st emergency contact first

_____

_____

_____

_____

_____

Allergies and type of reaction

_____ _____
_____
_____

Code Status_____

Advanced Directives: *check all that apply and please attach copies*

___ Do not resuscitate ___ Do not intubate ___Health Care Directive
___ Mental health Declaration ___ Guardian/Conservator ___ Financial Power of attorney
___ Health Care Power of attorney

Physician_____Clinic/hospital_____

Phone_____Address_____

Other medical providers:

_____

Name Address Phone

_____

Name Address Phone

_____

Name Address Phone

Please list Medical Insurance and Provider:

_____

_____

_____

_____

Are you or your spouse a War Time Vet? ____ yes ___ no

If yes, you may be eligible for VA benefits. Call Itasca County Veterans Service Office (218) 327-2858

Do you have state/county benefits including waivered services? ___ yes ___ no

If yes please attach a copy of your ID card.

If no and you are having difficulty funding privately, you may be eligible for services through county or state programs. Call the Itasca Resource building (218) 327-2941

If applying for Medical Assistance what date did you apply?_____

Name of your financial worker_____

Pharmacy

Name: _____phone#_____

Will they deliver? ____ yes ___ no if no, who will pick up prescriptions?

_____

Funeral Home:

Name:_____Address:_____

Phone:_____pre-paid funeral arrangements?___yes ___no

Medical Conditions/diagnosis_____

_____

_____

Surgical history_____

_____

_____

History of

Alcohol Abuse: yes_____ no_____ unknown_____

Drug Abuse: yes ____ no_____ unknown_____

Smoking: yes_____ no _____ currently smokes: yes_____ no _____

If yes how much?_____ if quit how long ago?_____

Communication Barriers

Vision: Yes ____ No ____ Correction _____

Hearing: Yes ____ No ____ Correction _____

Speech: Yes ____ No ____

Comments: _____

ADL's

Activity	Independent	Needs Assistance	Equipment	Comment
Bathing				
Dressing				
Grooming				
Toileting				
Transferring				
Walking				
Positioning				
Eating				

Assistive Device/Precautions_____walker Front wheeled or 4 wheeled with bench seat_____wheelchair_____toilet riser_____mechanical lift_____braces_____other_____

Skin Problems

_____

Digest Disorders

Diet_____Food
Allergies_____

Appetite_____Weight_____

Indigestion_____Heart Burn_____

Nausea Vomitting_____Constipation/Dirreah_____
Last BM_____ Nutritional status_____

Dentures_____other_____

Respirator Disorders

Shortness of Breath_____COPD_____

History of Bronchitis, pneumonia, sinus infection_____

Tuberculosis history_____

Use of inhalers/nebulizers/oxygen_____

Urinary Status

Catheter: Indwelling_____Suprapubic_____Condom_____

Change Schedule/Responsible person_____

Urinary:
Frequency_____Urgency_____Nocuria_____incontinence_____

History of UTI's or problem with kidney, bladder, or prostate_____

Other
information_____

Joint/Muscle disorders

Arthrits_____describe_____

Joint replacement_____
Describe_____

Pain_____Frequency/Intensisity_____

Relieved by_____

Muscular Disorders_____

Endocrine
Diabetes_____date of
onset_____BGM_____
Controlled by: Diet_____Oral
Med_____Insulin_____

Describe assistance needed_____

Other Endocrine_____

Cardiovascular Disease

Vital signs:_____peripheral Edema_____

High or low blood pressure_____

History of MI (myocardial infarction, Coronary artery disease, cardiovascular accident/stroke_____

Describe_____

Neurological disease

Seizure disorder_____paralysis_____

Neuopathies_____

Other_____

Mental Health Needs/Behavior Interventions

Alert___ Oriented to: Person___ Place___ Time___ Date___

Anxious___ Forgetful___ Depressed___ Wanders___ Cooperative___

Routinely sees a mental health professional___ Condition/illness Limits____

Behavior Socially Acceptable: Yes___ No___
Describe_____

Responds to Redirections_____

Social Supports

Satisfied with Quality of Life Yes___ No___ Family Involvement_____

Friends/Neighbors_____

Community Involvment_____

Church membership/involvement_____

Hobbies Recreation_____

Barriers to pursuing Social Activities_____

Other health Problems_____

Other Information_____

_____

Questions you may have for the facility_____

_____

_____

_____

_____