CONFIDENTIAL DATA APPLICATION

HEALTH INFORMATION FORM

LODGE AT WOLK MANOR
7000 Summit Circle Drive
Rochester, NY 14618
(585) 442-1950

LODGE AT WOLK MANOR
Assisted Living Memory Care
Confidential Data Application
Health Information Form

APPLICANT NAME: _____

ADDRESS: _____

_____

TELEPHONE #: _____ EMAIL: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: __ __ __- __ __-__ __ __ __

MEDICARE #: _____ MARITAL STATUS: _____

MEDICARE PART B COVERAGE ☐ YES ☐ NO

Other Health Insurance: _____ Occupation /Education: _____

Race: _____ Gender : F / M Residential background (born, raised):_____

Religion _____ Place of Worship: _____ Phone # _____

Wishes to be addressed as: _____

HEALTH INFORMATION

1. Contact information of applicant's primary care physician.

   Name _____ Address _____

   Phone _____ Fax number _____

2. List other physicians, including specialists; the applicant has seen in the last 5 years and telephone number (if available.)

   _____

   _____

** We will need written copies of all your prescription and non-prescription medications from your doctor on admission.

3. Name of current pharmacy: _____

4. Describe the applicant's past medical history, including hospitalizations, surgeries and any psychiatric illnesses.

_____

_____

5. Describe the applicant's medical diagnosis and any chronic illness or disability (i.e., cancer, diabetes, heart disease, stroke, neurological disease, serious infectious disease, etc.)

_____

_____

_____

6. Is the applicant able to:

			Comments
Bathe & dress with minimal assistance?	____ Y	___N	_____
Manage own medications?	____ Y	___N	_____
Climb stairs?	____ Y	___N	_____

7. Does the applicant:

Suffer from urinary or bowel incontinence?	____ Y	___N	_____
Utilize adaptive equipment (i.e., walker cane, wheelchair, scooter)?	____ Y	___N	_____
If yes, can the applicant operate/use adaptive equipment on their own?	____ Y	___N	_____
If yes, can the applicant transfer without another person's help to chair or bed?	____ Y	___N	_____

8. Please list 2 people who can be contacted in the event of an emergency:

name _____ name _____

address_____ address_____

state/zip _____ state/zip _____

telephone _____ telephone _____

9. Do you have advanced directives i.e. living will, DNR order, health care proxy? (Please attach a copy.)
   ☐ YES ☐ NO
   DNR _____ Living Will _____ Health care proxy _____

   DNI_____ POA_____
10. Which hospital do you prefer? _____

11. In the event of your death, who will handle funeral arrangements?

    Funeral Home _____

    The above information is true to the best of my knowledge, _____
    Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my physician to release to the Manager of The Lodge at Wolk Manor any and all medical information in his/her possession. Such medical information includes all information regarding my medical history, mental or physical condition or treatment.

Please promptly reply to this request, as Wolk Manor cannot act on my application without this response.

Thank you for your cooperation.

_____ _____
Signature **Print Name**

_____ _____
Person preparing this form **Relationship**
POA's must attach a copy.

FOR OFFICE USE ONLY

Medical Record #_____

Move In Date _____ Apartment # _____

Admitted from:_____
Address:_____