Wolk Manor

Assisted Living

ENRICHED LIVING CENTER

CONFIDENTIAL DATA APPLICATION

HEALTH INFORMATION FORM

WOLK MANOR

4000 Summit Circle Drive

Rochester, NY 14618

(585) 442-1950

WOLK MANOR
Enriched Living Center
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 or pharmacy choice upon admission:

____

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 (name)___________________________

   DNI _______ POA (name) _____________________________

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 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 #_________________________ New Telephone # __________________

Move In Date ____________________________ Apartment # ______________________

Admitted from:___________________________
Address:________________________________