ST. JOSEPH'S CARE GROUP

INPATIENT ADMISSION REQUEST FORM

Place Patient Label with Barcode Here

TO BE COMPLETED AND FAXED BY PHYSICIAN'S OFFICE OR FACILITY REQUESTING ADMISSION

Central Registration Telephone: (807) 343-2410
FAX: (807) 343-0144

Date: _____

☐ Hospital Program/Service _____ Telephone _____

☐ Community Specify _____

Referring Health Care Provider _____

Family Physician (if applicable) _____

Attending Physician St. Joseph's Hospital (MRP) _____

Admitting Diagnosis _____

Positive Culture: Yes ☐ If Yes, VRE ☐ MRSA ☐ C DIFF ☐ ESBL ☐ Other ☐
No ☑

Admission to:

Physical Rehab Programs

☐ Acquired Brain Injury
☐ Physical Rehab
☐ Amputee

Complex Care Programs

☐ Medically Complex
☐ Chronic Vent Program
☐ Hospice Palliative Care
☐ Geriatric Assessment & Rehabilitative Care
☐ Chronic Wound Program
☐ Lymphedema

Preferred Language _____

Contact Information _____
(Complete if community referral)

Telephone _____ _____
Home Work

Next of Kin _____
(Complete if community referral)

Telephone _____ _____
Home Work

_____ _____
Signature Date

SREQINPTADM

CLEAR FORM

Place Patient Label with Barcode Here

Medical Assessment Form Physician's Certificate

Reason for Transfer: _____

Physician's Signature: _____

CARE NEEDS ASSESSMENT (Nurse to Complete)

NEUROLOGICAL

Oriented Yes ☐ No ☐
Confused Always ☐ Occasional ☐ Day ☐ Night ☐
Impaired Cognition Yes ☐ No ☐
Forgetful Yes ☐ No ☐
Developmental Delayed Yes ☐ No ☐
A.B.I. Yes ☐ No ☐
Aphasia Yes ☐ No ☐

*Comments:*_____

SENSORY

Vision: (Impaired) Yes ☐ No ☐
Glasses Yes ☐ No ☐
Hearing Impaired Yes ☐ No ☐
Hearing Aid Yes ☐ No ☐

*Comments:*_____

BEHAVIOUR

Changeable Yes ☐ No ☐
Noisy-disturbing to others Yes ☐ No ☐
Physically aggressive Yes ☐ No ☐
Verbally aggressive Yes ☐ No ☐
Requires restraint Yes ☐ No ☐
Frequency _____

*Comments:*_____

NUTRITION

Special diet (specify) Yes ☐ No ☐
TPN Yes ☐ No ☐
Tube feed Yes ☐ No ☐

*Comments:*_____

GENITO/URINARY

Bladder control (abnormal) Yes ☐ No ☐
Foley Yes ☐ No ☐
Incontinent Yes ☐ No ☐
Ileal conduit Yes ☐ No ☐
Bowel control (abnormal) Yes ☐ No ☐
Colostomy Yes ☐ No ☐
Incontinent Yes ☐ No ☐

*Comments:*_____

GENERAL COMMENTS:

LIMBS

Arms/Legs(impaired) Yes ☐ No ☐
Amputation Yes ☐ No ☐

*Comments:*_____

SKIN

Wounds Yes ☐ No ☐
Describe
Dressing Yes ☐ No ☐
Describe
VAC Yes ☐ No ☐
Size _____
Type _____

*Comments:*_____

DRESSING

Needs to be dressed Yes ☐ No ☐

*Comments:*_____

AMBULATION

1 Person Assist ☐
2 Person Assist ☐
Aids used: Can ☐
Walker ☐
Wheelchair ☐
Mechanical lift ☐

*Comments:*_____

SPECIAL NEEDS (select all that apply)

Bariatric- Weight _____ ☐
Central Venous Line ☐
Chemotherapy in the last month or present ☐
Radiation ☐
Hemodialysis ☐
Peritoneal dialysis ☐
Tracheostomy ☐
Transplant ☐
Pain Control ☐
BiPap ☐
CPAP ☐

Other (describe):_____

Signature _____

Date _____