

OUR LADY OF PERPETUAL HELP HOME

760 POLLARD BLVD, S.W. ATLANTA, GA 30315
TEL # 404-688-9515 FAX # 404 588-9568

RESIDENT APPLICATION FOR ADMISSION

OUR LADY OF PERPETUAL HELP HOME is a free Home for Incurable Cancer patients regardless of age, race, color, creed, national origin, sex or handicap. The Home is one of seven homes in the United States founded by Rose Hawthorne Lathrop (daughter of Nathaniel Hawthorne) for patients whose care causes financial hardship and who cannot afford appropriate care elsewhere. The Home is supported solely by donations from the Public. No payment is accepted from the patient or their families. Families and competent patients must be informed that we provide comfort measures and that our care is not curative. All treatments must be completed before the patient is eligible for admission. Medications are prescribed by our Physician.

NAME _____ SS# _____ - _____ - _____ DATE ____ / ____ / ____
MAIDEN NAME _____ SEX _____ MARITAL STATUS _____
ADDRESS _____ COUNTY _____
CITY, STATE, ZIP _____
AGE ____ DOB ____ / ____ / ____ CITY/COUNTY/STATE OF BIRTH _____
FATHER'S NAME _____ MOTHER'S NAME _____ SPOUSE'S NAME _____
OCCUPATION _____ VETERAN? _____ RELIGION _____
HOSPITAL WHERE PATIENT WAS TREATED _____
PATIENT IS NOW: IN THE HOSPITAL AT HOME NURSING HOME OTHER _____
DIAGNOSIS _____ ONSET _____
Primary Site _____ Metastatic Sites _____
TREATMENTS: Date of last surgery ____ / ____ / ____ Type _____
Radiation: Yes No Chemotherapy: Yes No Other _____
Patient is aware of diagnosis? Yes No If no, Why? _____
Family is aware of diagnosis? Yes No

Documented proof of admitting diagnosis (such as Pathology report/CAT scan report), recent Chest X-ray report, History and Physical and Physician's signature are required before the application will be reviewed.

I AM AWARE OF AND ACCEPT THE POLICIES STATED AT THE TOP OF THE PAGE.

Signature of patient/responsible person is required.

Signature _____ Relationship _____
Address _____ Home Phone # (_____) _____ - _____
Address _____ Work Phone # (_____) _____ - _____

Social Worker's name _____
Phone # (_____) _____ - _____ Pager # (_____) _____ - _____

Patient's Name _____

Additional Diagnosis, Symptoms and Conditions: Please list all conditions.

Does Patient have any Communicable diseases? No Yes (Please specify)

Does Patient have any History of Mental Illness? No Yes (Explain)

Current Medications	Route	Dose	Frequency	Reason for
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				
7. _____				
8. _____				
9. _____				
10. _____				
11. _____				
12. _____				

CONTACTS:

1. Name _____ Relationship _____
Address _____ Home Phone # (_____) _____ - _____
City, St, ZIP _____ Work Phone # (_____) _____ - _____

2. Name _____ Relationship _____
Address _____ Home Phone # (_____) _____ - _____
City, St, ZIP _____ Work Phone # (_____) _____ - _____

PHYSICIAN'S NAME _____ Signature _____
Address _____ Home Phone # (_____) _____ - _____
City, St, ZIP _____

Patient's Name _____

ACTIVITIES OF DAILY LIVING

	Indep.	Super-vised	Minimal Assist	Extensive Assist	Totally Depend
Turning in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Locomotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MOBILITY

Bed Rest	<input type="checkbox"/>
OOB in Chair	<input type="checkbox"/>
Ambulatory	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>
Contracture	<input type="checkbox"/>
Amputation	<input type="checkbox"/>
Prosthesis	<input type="checkbox"/>
Other	_____

ELIMINATION

No Problem	<input type="checkbox"/>
Incontinent	<input type="checkbox"/>
Bladder	<input type="checkbox"/>
Bowel	<input type="checkbox"/>
Catheter	<input type="checkbox"/>
Size	_____
Ostomy	<input type="checkbox"/>
Other	_____

NUTRITION

Type of Diet _____
 Feeding Tube (Kind) _____
 IV _____
 Dentures None Full
 Bridge Partial
 WT. _____ Lbs. HT. _____ In.
 Hx. Of Alcohol abuse? Y N
 Present Alcohol Intake?
 None Social Heavy
 Smokes? Y N

No Problems
 Problems with:
 Chewing
 Swallowing
 Oral Pain
 Other _____
 Dehydration
 Poor Intake
 Malnutrition

COMMUNICATION

No Problems
 Mode of Communication:
 Speech Gesture
 Writing Sign
 Communication Board
 Other _____
 Speaks English? Y N
 Speaks Foreign Language?

SKIN CONDITION

Intact
 Decubitus (Where) _____

 Edema (Where) _____

 Other Lesions _____

MENTAL STATUS

Alert Confused
 Oriented Combative
 Quiet Abusive
 Noisy Anxious
 Lethargic Wanders
 Comatose Forgetful

SENSORY

Vision:
 Normal R L
 Glasses Y N
 Contacts R L
 Blind R L
 Other _____

Hearing
 Normal R L
 HOH R L
 Hearing Aid R L
 Deaf R L
 Other _____

EQUIPMENT

Oxygen
 Suction
 Trapeze
 Restraints
 Tracheostomy
 Other

ALLERGIES (Specify)

No Known Allergies
 Food Allergies _____
 Medication Allergies _____

 Pet Allergies _____
 Other Allergies _____

ACTIVITIES PREFERENCES

Day Room Cards Writing
 Outdoors Games Reading
 Individual Arts Movies
 Group Crafts Religious
 Music TV
 Other _____

TREATMENTS AND OTHER PERTINENT INFORMATION (Social, Nursing, Medical, etc.): _____

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Name of person giving information _____

Signature _____

Phone # (_) _____ - _____