SWAN BROOK

Resident's Application

(01/10)

Resident's Name_______________________ Address ____

City, State, ___________________________________ Zip _______________ Phone_______________________

Date of birth_____________ ***Resident Representative*** ____

Social Security #_________________ . ____

Male or Female ____

Phone # ____

Current Medical Diagnosis ____

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() The resident can safely self-administer prescriptions and over the counter drugs.

() The resident requires supervision/assistance to self administer prescriptions and over the counter drugs.

Dietary Needs *(list dietary requirements or special preparation requirements)*

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Allergies ____

Activities of Daily Living Assessment

	Independent	Supervise	Assisted	Dependent	Comments
Climbing stair					
Bathing					
Grooming					
Hair care					
Oral Hygiene					
Dressing					
Eating					
Laundry					
Toileting		Incontinent blad	Incontinent bowel		continent
Ambulation		cane	Walker	wheelchair	
Take Meds					

Physician Name____________________________ **Address** ____

Phone # ____________________________________ ____

Please list all Insurances and supplemental **Medicare#**________________________________

____ **policy** ________________________________

____ **Hospital choice**________________________________

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Person to call in an Emergency

Name ____ **Do you have a P.O.A?** **yes or no**

Address ____ **Do you have a health care proxy?** **yes or no**

Phone ____ **Do you have a D.N.R?** **yes or no**

Cell Phone ____

Relation to applicant ________________________________

Signature of Applicant ___________________________________**Date**__________________