



Department of Behavioral Health, Developmental Disabilities and Hospitals
ELEANOR SLATER HOSPITAL
Admissions Department
111 Howard Avenue
Cranston, RI 02920

Office – 401-462-3433
Fax – 401-462-6958

APPLICATION FOR ADMISSION

Name of Applicant: _____

Residence: _____

Date of Birth: _____ Gender: Male Female U.S. Citizen: Yes No

Language Preference: _____

INCLUDE PHOTOCOPIES OF ALL MEDICAL COVERAGE CARDS

Social Security #: _____ Name of insured, if other than applicant: _____

Medicare #: _____ Federal Medicare Replacement Plan (HMO) Agency: _____

If supplemental plan to Medicare please specify: _____ ID #: _____

Blue Cross #: _____ Veteran's #: _____ Other: _____

Medical Assistance #: _____ ID #: _____

(R.I. only) If pending, list name of office/worker to contact

Both the Long-Term Care Medicaid application and the Long-Term Care referral are required at the time of application.

Date application submitted: _____, Date referral made: _____ . Please attach copies of both the application and the referral.

Referral from (home, nursing home, community agency, etc.):

Name: _____ Address: _____

Contact Name: _____ Telephone: _____

Family, significant other supports

<u>Name</u>	<u>Address</u>	<u>Telephone (home/work/cell)</u>	<u>Relationship</u>

How often have family, significant other supports visited the applicant in the last two months?

- Daily 2-3 times per month
 More than a week Once a month
 Once a week Less than once a month N/A

How often have they provided care/assistance to the applicant in the last two months?

- Daily 2-3 times per month
 More than a week Once a month
 Once a week Less than once a month N/A

Advanced Directive: ***Please provide copies of any known "Advanced Directive".***

Communication Preferences

Living Will: Yes No

Mail

Durable Power of Attorney for Healthcare: Yes No

Phone _____

Is Guardianship pending? Yes No

*Email _____

Eleanor Slater Hospital (ESH) is a facility that provides Long-Term Care; patients accepted for admission **must qualify for hospital level of care**. In addition, attempts are made to accommodate patients' wishes, however the appropriate campus and unit for admission will be determined by the ESH Admission Team. Internal unit transfers between Cranston and Burrillville (Zambarano Campus) are at the discretion of the ESH clinical treatment team at any time following admission. For health and safety reasons, the patient and/or guardian must agree to basic care and personal hygiene throughout the duration of the hospital course. All least restrictive options must be exhausted prior to ESH referral and documented below. Documentation of all alternative referrals may be requested when applicable. Please note, for those patients receiving treatment from a community provider, i.e. community mental health center, an application from the acute care hospital and the community agency must be received in order for the ESH referral to be complete. The application will be considered a partial application and the applicant will not be considered for admission until both parties have submitted their portion of the application. It is the responsibility of the community providers to consult and agree upon ESH referral; ESH staff **will not** notify community providers when an application is incomplete. Once completed an ESH representative will notify the acute care hospital of the plan to proceed. If / when patients no longer qualify for hospital level services as determined by the current acute care treatment team, discharge to a less restrictive environment becomes mandatory under federal guidelines. Both the patient and family/guardian are to participate and support discharge planning efforts as deemed appropriate by the clinical treatment team. The patient and family/guardian will be notified prior to any such discharge referral.

The community agency is in agreement with the ESH referral: YES NO
 The community agency agrees to submit their portion of the ESH application: YES NO

Reason for referral to Eleanor Slater Hospital (Circle all that apply and elaborate below):

Medical	Behavioral	Psychological	Psychiatric
<hr/>			

Has the patient sought admission elsewhere? Yes No

If yes where? What were their decisions? _____

If no please explain. _____

Does the patient have a discharge goal after Eleanor Slater Hospital? Yes No

If yes what is the goal: Home alone Assisted living
 Home with family Group home
 Nursing home Other (Please specify): _____

Who will be responsible for this patient's care?

<u>Name</u>	<u>Address</u>	<u>Telephone (home/work/cell)</u>	<u>Relationship</u>
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This individual's active, early involvement in the admission process is strongly encouraged to facilitate the eventual discharge goal. A conference may be requested prior to admission.

If no discharge goal exists, please explain long-term goals for this patient 1-5 years from now:

ALL INFORMATION MUST BE COMPLETE AND ACCURATE. APPLICATIONS WHICH INCLUDE "SEE ATTACHED" WILL BE CONSIDERED INCOMPLETE AND WILL NOT BE REVIEWED UNTIL ALL MATERIALS ARE RECEIVED. PLEASE INCLUDE COPIES OF SUPPORTIVE DOCUMENTATION: *Physician progress notes, physician orders, nurses' notes, consultations, history and physical examinations, therapy notes, etc. Two weeks of progress notes is typically sufficient unless otherwise requested.*

To be completed by physician, nurse, or case manager – please check appropriate boxes.

<u>ACCESS/OSTOMY</u>	<u>MEMORY</u>	<u>COMMUNICATION</u>	<u>SENSORY</u>
<input type="checkbox"/> NG/G/J Tube	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Hearing impairment
<input type="checkbox"/> IV/IV access	<input type="checkbox"/> Mildly impaired	<input type="checkbox"/> Language barrier	<input type="checkbox"/> Vision Impairment
<input type="checkbox"/> Trach	<input type="checkbox"/> Moderately impaired	<input type="checkbox"/> Comprehends	<u>CONDITIONS</u>
<input type="checkbox"/> Ostomy	<input type="checkbox"/> Severely impaired	<input type="checkbox"/> Able to relate needs	<input type="checkbox"/> Pressure sores/wound care
		<input type="checkbox"/> Aphasic/non-communicative	<input type="checkbox"/> Contractures
<u>BEHAVIOR</u>		<input type="checkbox"/> ADL Assistance	
<input type="checkbox"/> SI		<input type="checkbox"/> Treatment Non - Compliance	
<input type="checkbox"/> HI		<input type="checkbox"/> Medication Non-Compliance	
<input type="checkbox"/> Severe Affective Symptoms		<input type="checkbox"/> Medication Change	
<input type="checkbox"/> Unresolved Psychosis <input type="checkbox"/> AH <input type="checkbox"/> VH <input type="checkbox"/> PI <input type="checkbox"/> Delusions		<input type="checkbox"/> Restraints Needed <input type="checkbox"/> yes <input type="checkbox"/> no	
<input type="checkbox"/> Cognitive Impairment			

Please attach a description of any particular management issues of which the Eleanor Slater Hospital Admission Team should be aware.

<u>ADL</u>	Independent	Needs assistance	Unable	<u>ALLERGIES:</u>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ambulation with device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bathe self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>DIET:</u>
Dress self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feed self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toilet/commode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bedpan/urinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT: _____
				WEIGHT: _____

CONTINENCE

Continent Incontinent urine/feces

Special equipment needed: _____

Air fluidized beds: _____

Other (Describe): _____

FOOD & FLUID INTAKE:

Excellent Fair

Good Poor

DIAGNOSES/PROBLEMS:

1. (Primary Diagnosis)	4.
2.	5.
3.	6.

MEDICATIONS (including Dose & Routine) TPN and IV

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PROGNOSIS Good Fair Poor Guarded

SERVICES NEEDED:

<input type="checkbox"/> PT (Describe): _____	<input type="checkbox"/> Respiratory / Ventilator: _____
<input type="checkbox"/> OT (Describe): _____	<input type="checkbox"/> Skin / wound care: _____
<input type="checkbox"/> Speech (Describe): _____	<input type="checkbox"/> Dialysis: _____
	<input type="checkbox"/> Other: _____

INFECTION CONTROL

MRSA VRE ACTIVE TB ESBL

Special Isolation (Describe): _____

SIGNATURE SECTION: *No personal health information can be sent via email

_____ Date: _____
Applicant's Signature (If unable to sign, guardian or relative)

PHYSICIAN VERIFICATION:

Name of Physician: _____ Telephone: _____ Date of last examination: _____
(Print)

Signature of Physician: _____ Date: _____