# Pre-Admission/Admission History

***This information is available in alternate formats upon request by contacting the individual identified below.***

To prepare for admission to ______________________, please complete the questions in the attached forms. We have found through experience that the more we know about our residents prior to admission to our facility, the better able we are to provide care after admission. Often details of a person's past can be important factors to providing care in our facility, because we are better able to understand the resident. Knowing this information can open up amazing doors, and we want our residents to know that we care and that their voice can and will be heard.

This information will be shared with staff and assists us in getting to know you/the resident better. You know the care that is required for yourself or your family member better than anyone else and no one provides that care with more love and concern than you.

If you have any questions, please contact __________________________(insert name) at _____________(insert phone number) or ____________________________(insert email).

You are required to bring the following documents to the pre-admission/admission meeting:

- ☐ Income Tax Notice of Assessment for 20__
  - If married, both assessments are required. If you are unable to locate the Income Tax Notice of Assessment, please call Canada Customs and Revenue Agency at 1-800-959-8281 for a free replacement assessment.
- ☐ Power of Attorney Papers (if completed)
- ☐ Health Care Directive (if completed)
- ☐ Manitoba Health Card
- ☐ Social Insurance Number
  - If married, both Social Insurance Numbers required.
- ☐ Banking Information (direct withdrawal information)

Thank you in advance for taking the time to complete the attached package.

## Demographics

Full **Legal** Name: ☐ Mr. ☐Mrs. ☐ Ms. ☐ Miss_______________________________________________

Maiden Name (if applicable): __________________ Preferred Name: ____________________________

Date of Birth: ________________________________ Place of Birth: ______________________________

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Family of Origin/Descent (nationality/ethnicity): _______________________________________________

Name of father: ____________________ Name of mother (and maiden name): ___________________

Number of siblings: ____________ Sisters: ______________ Brothers: _________________

Names of siblings (in order from oldest to youngest):

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Name of spouse (if applicable): ____________________ Date of marriage: ________________________

Place of marriage: _________________ Date spouse deceased (if applicable): ___________________

Names of previous spouse(s) and dates/places of marriage (if applicable):

_________________________________________________________________________________________

What would you like us to know about your marriage/relationship? _____________________________

_________________________________________________________________________________________

Number of children: ____________ Daughters: ______________ Sons: __________________

Names of children (oldest to youngest). Please include names of spouses (if applicable) and current location (city/town):

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Number of grandchildren: _____________ Number of great grandchildren: _______________

Any other important relationships: _________________________________________________________

_________________________________________________________________________________________

****Please feel free to attach any other family information you feel may be important to us. ****

**About the Applicant**

Language(s) spoken: ________________________________ Preferred Language: _______________

Language(s) understood (if different than spoken): ________________________________________

Church affiliation: ________________________ Baptism Date (if applicable/known): ____________

Church denomination: ___________________________

Education completed (Grade): ______ University or College: _______________________________

Past occupations/work life:

_________________________________________________________________________________

_________________________________________________________________________________

Past volunteer/community involvement: _______________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Favorites:

- Time of year ______________________ - Color _________________________________
- Sport ____________________________ - Holiday _______________________________
- Music ____________________________ - Pets __________________________________
- Food (including drinks/snacks) _________________________________________________
  _________________________________________________________________________
- TV/Movie __________________________________________________________________
- Books _____________________________________________________________________

Things they love/ loved to do (please circle and add any additional):

- gardening - sewing - quilting - walking - reading - music
- cooking - woodwork - games - cards - visiting - volunteering
- Other: ______________________________________________________________________

Special memories/ things they are proud of:

_________________________________________________________________________________

_________________________________________________________________________________

Special skills, talents and/or interests:

_________________________________________________________________________________

_________________________________________________________________________________

**Functional Assessment** (Describe any disabilities or problems if any)

Speech: ☐ Unimpaired/Clear
☐ Slurred ☐ Garbled ☐ Word-finding Difficulties

Vision: ☐ Unimpaired ☐ Glasses ☐ Sees well with glasses ☐ Sees poorly with glasses
☐ Wears glasses all the time ☐ Wears glasses for reading ☐ Does not wear glasses

Hearing: ☐ Unimpaired ☐ Hearing aid(s) ☐ Left ear ☐ Right ear
☐ Hears well with aid(s) ☐ Hears poorly even with aid(s) ☐ Does not wear

Teeth: ☐ Own teeth ☐ Dentures (Top and Bottom) ☐ Upper Denture ☐ Lower Denture
☐ Partial Upper ☐ Partial Lower

Mobility: ☐ Independent ☐ Uses 2 wheeled walker ☐ Uses 4 wheeled walker
☐ Wheelchair ☐ Mechanical Lift
Do they own their walker/wheelchair? ☐ Yes ☐ No

Are there any problems getting the resident to take medications or treatments? ____________

_________________________________________________________________________________

Food/Diet Texture (cut-up, minced, pureed etc.):__________________________________________

Food Likes: _________________________________________________________________________

Food Dislikes:_______________________________________________________________________

Diet Restrictions:____________________________________________________________________

**Funeral Arrangements**

Name of Funeral Home: ______________________________ Phone #: ________________

- Cremation? ☐ Yes ☐ No
- Organ donor? ☐ Yes ☐ No
- Whole body donation? ☐ Yes ☐ No ☐ Document(s) provided

## Medical and Surgical History

Please list your/the resident's medical diagnosis/history, please include any surgeries you/the resident have had along with when/year, if known.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Do you/the resident have a pacemaker?** ☐ Yes ☐ No

**Allergies** (please list all allergies - drug, food, environmental, ***including reaction(s***):

______________________________________________________________________________

## Applicant's Present condition

*Check all of the following which describe present condition. (If occur only occasionally, or in the past indicate when).*

☐ Sociable
☐ Cheerful
☐ Cooperative
☐ Independent
☐ Too Independent
☐ Mentally Alert
☐ Lethargic
☐ Angry
☐ Cries Easily
☐ Excessive Laughing
☐ Unexpected Angry Outbursts
☐ Prefers to Be Alone
☐ Prefers Groups
☐ Noisy
☐ Silent
☐ Slightly Forgetful
☐ Very Forgetful
☐ Good Long-Term Memory
☐ Good Short-Term Memory

☐ Withdrawn
☐ Generally Unhappy
☐ Poor Judgement
☐ Reserved
☐ Paranoid
☐ Sensitive
☐ Easily Fatigued
☐ Loss of Self-Esteem
☐ Worrier
☐ Attention Seeking
☐ Wants To Get Well
☐ Addiction To: _______________
☐ Confused
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Falls

☐ Physically Aggressive
☐ Verbally Aggressive
☐ Refuses/Resists Care
☐ Sexually Inappropriate
☐ Anxious
☐ Depressed
☐ Has Talked of Suicide
☐ Has Attempted Suicide
☐ Suspicious
☐ Entering Rooms
☐ Wandering
☐ Elopement Risk
☐ Sees Things Not There
☐ Hears Things
☐ Hoarding
☐ Knows People
☐ Knows Places
☐ Knows Times

**Additional Questions**

- How would you describe yourself/the resident? (Include personality traits, attitudes, and values/beliefs and if there has been any changes)
  ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________
- How do you/does the resident react to losses in life/changes that have occurred (describe how you/the resident has/have coped, what gave you/the resident strength/helped, what didn't)
  ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________
- What upsets/frustrates you/the resident? ____________________________________________
  ______________________________________________________________________________
- Are there any difficult dates or dates of significance for you/the resident? (anniversaries, dates of loved one's passing, etc. Please include dates) ________________________________________
  ______________________________________________________________________________
- Have you/the resident been told about coming into a Personal Care Home? ☐ Yes ☐ No
  - If yes, how do you/the resident feel about moving to a Personal Care Home?
    ___________________________________________________________
    ___________________________________________________________
  - Family's feelings toward moving into the Personal Care Home?
    ___________________________________________________________
    ___________________________________________________________
- Are there any cultural considerations you think we should be aware of? ______________________
  ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________

## What Matters to You?

What matters most to you/the resident? ________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What would you/the resident like health care providers to know about you/the resident? ______________

________________________________________________________________________________

________________________________________________________________________________

What do you/the resident need in order to feel comfortable and safe in your/the resident care journey?

________________________________________________________________________________

________________________________________________________________________________

What is important to you/the resident in your/the residents care? _______________________________

________________________________________________________________________________

________________________________________________________________________________

What is most important to you/the resident in your/the resident routine and in their life? ______________

________________________________________________________________________________

________________________________________________________________________________

## Normal Day

What does your/the resident's normal day look like (include time that you/the resident gets up, goes to bed, naps, how time is spent during the day, activities, night habits/routines and best/worst time of day).

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Is there any other information you think we should know/would like us to know, to assist us in caring for you/the resident?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Contact Information:**

The following is information we will need to have on your/the resident's chart for contact information. Please understand that we expect the "first contact" we reach via telephone to relay information to other family members and we will not call all family members. The "first contact" should be someone who is willing to take phone calls and is in charge of finances/ health care decisions.

| **First Contact** | **Second Contact** |
|---|---|
| Name: ______________________________________<br>Relationship to Resident:______________________<br>Address: ___________________________________<br>Phone number(s): ____________________________<br>____________________________________________<br><br>E-Mail Address:________________________________<br><br>Power of Attorney (POA)? ☐ Yes ☐ No<br>Health Care Proxy? ☐ Yes ☐ No | Name: ______________________________________<br>Relationship to Resident:______________________<br>Address: ____________________________________<br>Phone number(s): _____________________________<br>____________________________________________<br><br>E-Mail Address:______________________________<br><br>Power of Attorney (POA)? ☐ Yes ☐ No<br>Health Care Proxy? ☐ Yes ☐ No |

***(Health Care Proxy is the persons legally designated by the individual to make health care decisions)***
***If providing an e-mail address, please provide consent, either verbal or written, that you have read the attached Email Risk Acknowledgment and Agreement and agree to it.***

If applicable, please fill out the following:

- Third Party Insurance # and type: ____________________________
- Veteran #: _______________
- Treaty #: ________________
  - Band Name:_________________
- Employment and Income Insurance (EIA) ☐ Yes ☐ No Case# (if known)_____________
- Is the resident under the Public Guardian and Trustee? ☐ Yes ☐ No Case# (if known)______

*Please sign once completed. Please bring the completed questionnaire with you to the pre-admission meeting that will be set up with you, or return this at your earliest convenience to ___________________(insert personal care home name) Attention: ________________________(insert staff person's name completing the pre-admission/admission history).*

Completed by:_______________________________
*Name/Relationship to Resident*

Date Completed:_________________________

Reviewed/Updated:__________________________
*Social Worker/Designate*

Date Reviewed:________________________

*Email Risk Acknowledgement and Agreement*

*Southern Health-Santé Sud cares about your privacy. Southern Health-Santé Sud has policies and procedures in place that require that any information shared by you electronically will be treated and managed in accordance with our obligations under The Personal Health Information Act.*

*It is important to note, however, that there is always risk when using electronic communications. Email is not considered secure and Southern Health-Santé Sud is not responsible for the security of your email service or your own device (for example, your smartphone or tablet) or the internet connection that you are using.*

*Our staff are required to guard your personal health information and use it only as legislation allows. That will remain the case with any personal health information our staff receive from you.*

*Before we can start any electronic communication with you about your health, we need you to acknowledge the risk, including the risk to your personal health information as described above. By choosing to communicate with your health care provider by electronic methods, you acknowledge and agree that:*

- *there remains risks associated with this method of communication and waive any and all liability of Southern Health-Santé Sud, it's affiliates, and the health professionals involved for any damages or claims arising out of or in connection with your electronic communication, even if Southern Health-Santé Sud, it's affiliates, and the health professionals have been advised of the possibility of such liabilities;*
- *emails to your health care provider should not be time sensitive or used in cases of medical emergency or crisis;*
- *in the case of a medical emergency or crisis, to call 911;*
- *urgent messages or needs should be relayed to your health care provider using regular telephone communications;*
- *electronic communication is not a substitute for care normally provided during a scheduled appointment;*
- *appointments should be made to discuss any new issues, sensitive matters or where clinical advice is being sought; and*
- *emails received may not be responded to by your health care provider and any follow up may be conducted by telephone or scheduling an appointment.*

*Please contact your health care provider if you have any concerns or questions or if you are not comfortable with the risks described here. Your health care provider can support you in finding another way to connect to support your health needs.*