**EMERGENCY ROOM/HOSPITAL ADMITTANCE FORM**

Form to be completed by residential staff prior to bringing the individual with intellectual disability to the Emergency Room or admitting the individual to the hospital.

Date: _____ Completed by: _____ Relationship to Individual: _____

Name: _____ Nickname/Likes to be called: _____

DOB: _____ Soc Sec #: _____

Address: _____

_____

Phone #: _____

**Health Insurance (Type & Numbers)**

Primary: _____

Secondary: _____

Allergies: _____

Living Status: Group Home ____ Family Living ____ Lives Independently _____ Other_____

Nursing Supports Available at provider agency? (circle) Yes or No; RN and/or LPN Name: _____

**Emergency Contacts**

Name (Provider Agency): _____ Name (Family):_____

Phone Number: _____ Relationship: _____

Phone Number (After Hours): _____ Phone Number: _____

County Contact Person: _____

Phone Number: _____

Phone Number (After Hours): _____

Primary Care Physician: _____

Phone Number: _____

Reason for ER visit today:

Neurologist: _____

Phone Number: _____

Current Medical Problems/Diagnoses:

Psychiatrist: _____

Phone Number: _____

Level of Intellectual disability (circle one):

Mild Moderate Severe Profound

**Consent Status:**

- ☐ CAN give own consent
- ☐ CANNOT give own consent. Has a Legal Guardian.

  Legal Guardian: _____ Phone Number: _____
- ☐ CANNOT give own consent. Does not have a Legal Guardian. Has a Substitute Healthcare Decision Maker.

  Name: _____ Phone Number: _____

  Medical Durable POA: _____ Phone Number: _____

**Resuscitation Status:**

- ☐ DNR****
- ☐ Full Resuscitation

If DNR, List Reason: _____ Date DNR Given: _____ By Whom: _____

Consent for Release of Information to Provider (circle one): Yes No

Date of Last Tetanus: _____ Date of Last PPD: _____ Date of Last Flue Shot: _____

Date of Last Pneumovax: _____ Date of Hepatitis B Vaccines: _____

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**Communication**
- ☐ Able to Communicate
- ☐ Communication Difficulties/Uses verbalizations
- ☐ Communication Difficulties/Uses gestures
- ☐ Not able to communicate needs
- ☐ Unable to use call bell

**Vision**
- ☐ Normal
- ☐ Low Vision
- ☐ Blind
- ☐ Wears glasses
- ☐ Wears contact lenses

**Hearing**
- ☐ Normal
- ☐ Hard of hearing (Left/Right)
- ☐ Deaf (Left/Right)
- ☐ Hearing Aid (Left/Right)

**Supportive Devices**
- ☐ Padded side rails
- ☐ Splints
- ☐ Braces
- ☐ Helmet
- ☐ Other: _____

**Toileting Ability**
- ☐ Continent
- ☐ Needs Assistance
- ☐ Incontinent
- ☐ Catheterized
- ☐ Other: _____

**Medication Administration**
- ☐ Independent/Self Medicates
- ☐ Medication Administered by Staff

**Dining/Eating**
- ☐ Independent
- ☐ Needs Assistance
- ☐ Totally Dependent
- ☐ Fed Through a Tube
- ☐ Other:_____

**Diet Textures**
- ☐ Regular
- ☐ Chopped
- ☐ Ground
- ☐ Puree
- ☐ Thickened Liquid

Diet type: _____
Last Meal Eaten: _____

**Ambulation**
- ☐ Independent
- ☐ Needs Assistance
- ☐ Walker
- ☐ Wheelchair
- ☐ Steady
- ☐ 1 Person
- ☐ Cane
- ☐ Unsteady
- ☐ 2 Person
- ☐ Crutches
- ☐ Non-Ambulatory

**Personal Hygiene**
- ☐ Independent
- ☐ Special Needs _____

**Oral Hygiene**
- ☐ Independent
- ☐ Special Needs _____
- ☐ Dentures (Upper/Lower/Partial)

Head of Bed Elevated (Yes/No)

**SPECIAL NEEDS**

**Usual Response to Medical Exams:** ☐ Cooperates ☐ Partially Cooperates ☐ Resistant/Becomes Agitated ☐ Fearful/Anxious

- ☐ Any sedation required for clinical visits _____
- ☐ Special positioning required for examination _____
- ☐ Staff required for assistance with exams _____
- ☐ Requires limited waiting periods for exams
- ☐ Prefers early day appointments ☐ Prefers end of day appointments
- ☐ Special communication device/method _____

**Pain Response:** ☐ Normal ☐ Unique _____

**Medical History:** ☐ Known ☐ Unknown

For information, contact: _____ Relationship: _____

Phone: _____ Address: _____

**SURGICAL**

List all previous surgeries and dates (most recent first):

_____
_____
_____
_____
_____

Any previous problems with anesthesia:

☐ No ☐ Yes _____

List any serious trauma or broken bones: _____

_____

**MEDICAL**

List all serious medical illnesses (e.g., pneumonia, heart attack) and ongoing medical problems (e.g., diabetes, high blood pressure, epilepsy):

_____
_____
_____

**PSYCHIATRIC**

List all major behavioral and psychiatric diagnoses (e.g., depression, schizophrenia, self-injurious behavior): _____

_____

**WOMEN'S HEALTH**

Currently Pregnant: ☐ Yes ☐ No

Past History of Childbirth: ☐ Yes ☐ No

Age menstruation started: _____

Age menstruation stopped: _____

☐ Still menstruating

Date of Last PAP: _____

History of Abnormal PAP?

☐ Yes ☐ No _____

Date of Last Mammogram: _____

**MEN'S HEALTH**

Date of Last prostrate Exam: _____

Date of PSA: _____

☐ Normal ☐ Abnormal ☐ N/A