Bethany
HEALTH CARE CENTER
A Sponsored Ministry of the Sisters of St. Joseph of Boston
97 Bethany Road | Framingham, MA 01702-7237 | (508) 872-6750 | Fax: (508) 875-5425

APPLICATION FOR ADMISSION

(Please complete all pages)

Applicant Name: _____ Date: _____

Address: _____

_____

Telephone Number(s): _____ Email:_____

Birthdate: _____ Age: _____ ( ) Male ( ) Female

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced

Religion: _____ Education Level: _____ Primary Language: _____

Primary Care Physician

Name: _____

Address: _____

Phone Number(s): _____

Responsible Party

Name: _____

Address: _____

*Phone Number(s):*_____

Relationship:_____

Has applicant been screened for Long Term Care eligibility if Medicaid? ( ) Yes ( ) No

Agency Name and Phone Number: _____

We have many applicants at various stages in the pre-admission process.
Once all the documentation is completed, each applicant will be considered for admission when an appropriate placement is available. We will contact you at that time.

Medical Information

Does applicant have a diagnosis of depression or mental illness? ( ) Yes ( ) No

Onset of diagnosis (date): _____

Principal Diagnosis:_____

Other Diagnosis, including Past Medical History: _____

_____

Surgeries: _____

_____

Please check all that apply

Ambulation
( ) Independent
( ) w/Assist
( ) Walker
( ) Cane
( ) Wheelchair
( ) Bed bound
( ) Transfers
  ( ) Independent
  ( ) Assist

Continence
Bladder ( )
  ( ) Continent
  ( ) Incontinent
Bowel ( )
  ( ) Continent
  ( ) Incontinent
  ( ) Catheter
  ( ) Ostomy

Dressing
( ) Independent
( ) w/Assist
( ) Total Care

Feeding
( ) Independent
( ) Set-Up
( ) w/Assist
( ) Must be Fed
( ) Special Diet

Bathing
( ) Independent
( ) Supervision
( ) w/Assist
( ) Total Care

Mental Status
( ) Verbal
( ) Non-responsive
( ) Alert
( ) Oriented
( ) Confused
( ) Forgetful

Behavior
( ) Cooperative
( ) Depressed Mood
( ) Withdrawn
( ) Agitated
( ) Noisy
( ) Wanders

Other
Height _____
Weight _____
( ) Hearing Aids
( ) Eyeglasses
( ) Dentures
( ) Allergies _____

Medications *(attach additional sheet if needed)*	***Dosage***	***Frequency***
_____	_____	_____
_____	_____	_____

Other Specialty Doctors Visited

_____

_____