

Maple Woods Assisted Living and Memory Care  
40170 C R 257 Cohasset MN 55721  
Phone (218) 999-9072 Fax (218) 999-9068  
Email: Mwoods@paulbunyan.net

Confidential Placement Resident Application:

Date: \_\_\_\_\_

Name \_\_\_\_\_  
Last First ( legal) Middle preferred

Address \_\_\_\_\_

Phone \_\_\_\_\_

County \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Divorced \_\_\_ Never married \_\_\_ Widowed

Emergency and family contact name, address, and phone number: List 1<sup>st</sup> emergency contact first

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies and type of reaction

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Code Status** \_\_\_\_\_

**Advanced Directives:** *check all that apply and please attach copies*

Do not resuscitate     Do not intubate     Health Care Directive  
 Mental health Declaration     Guardian/Conservator     Financial Power of attorney  
 Health Care Power of attorney

**Physician** \_\_\_\_\_ **Clinic/hospital** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Address** \_\_\_\_\_

**Other medical providers:**

Name	Address	Phone
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Name	Address	Phone
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**Please list Medical Insurance and Provider:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you or your spouse a War Time Vet?**     yes     no

If yes, you may be eligible for VA benefits. Call Itasca County Veterans Service Office (218) 327-2858

**Do you have state/county benefits including waived services?**     yes     no

If yes please attach a copy of your ID card.

If no and you are having difficulty funding privately, you may be eligible for services through county or state programs. Call the Itasca Resource building (218) 327-2941

If applying for Medical Assistance what date did you apply? \_\_\_\_\_

Name of your financial worker \_\_\_\_\_

**Pharmacy**

Name: \_\_\_\_\_ phone# \_\_\_\_\_

Will they deliver? \_\_\_ yes \_\_\_ no if no, who will pick up prescriptions?

Funeral Home:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ pre-paid funeral arrangements? \_\_\_ yes \_\_\_ no

**Medical Conditions/diagnosis** \_\_\_\_\_

**Surgical history** \_\_\_\_\_

**History of**

Alcohol Abuse: yes \_\_\_ no \_\_\_ unknown \_\_\_

Drug Abuse: yes \_\_\_ no \_\_\_ unknown \_\_\_

Smoking: yes \_\_\_ no \_\_\_ currently smokes: yes \_\_\_ no \_\_\_

If yes how much? \_\_\_\_\_ if quit how long ago? \_\_\_\_\_

**Communication Barriers**

Vision: Yes \_\_\_ No \_\_\_ Correction \_\_\_\_\_

Hearing: Yes \_\_\_ No \_\_\_ Correction \_\_\_\_\_

Speech: Yes \_\_\_ No \_\_\_

Comments: \_\_\_\_\_

**ADL's**

Activity	Independent	Needs Assistance	Equipment	Comment
Bathing				

Dressing				
Grooming				
Toileting				
Transferring				
Walking				
Positioning				
Eating				

**Assistive Device/Precautions** \_\_\_\_\_ walker Front wheeled or 4 wheeled with bench seat \_\_\_\_\_ wheelchair \_\_\_\_\_ toilet riser \_\_\_\_\_ mechanical lift \_\_\_\_\_ braces \_\_\_\_\_ other \_\_\_\_\_

**Skin Problems**

\_\_\_\_\_

**Digest Disorders**

Diet \_\_\_\_\_ Food \_\_\_\_\_

Allergies \_\_\_\_\_

Appetite \_\_\_\_\_ Weight \_\_\_\_\_

Indigestion \_\_\_\_\_ Heart Burn \_\_\_\_\_

Nausea Vomitting \_\_\_\_\_ Constipation/Dirreah \_\_\_\_\_

Last BM \_\_\_\_\_ Nutritional status \_\_\_\_\_

Dentures \_\_\_\_\_ other \_\_\_\_\_

**Respirator Disorders**

Shortness of Breath \_\_\_\_\_ COPD \_\_\_\_\_

History of Bronchitis, pneumonia, sinus infection \_\_\_\_\_

Tuberculosis history \_\_\_\_\_

Use of inhalers/nebulizers/oxygen \_\_\_\_\_

**Urinary Status**

Catheter: Indwelling \_\_\_\_\_ Suprapubic \_\_\_\_\_ Condom \_\_\_\_\_

Change Schedule/Responsible person \_\_\_\_\_

Urinary:

Frequency \_\_\_\_\_ Urgency \_\_\_\_\_ Nocuria \_\_\_\_\_ incontinence \_\_\_\_\_

History of UTI's or problem with kidney, bladder, or prostate \_\_\_\_\_

Other

information \_\_\_\_\_

**Joint/Muscle disorders**

Arthritis \_\_\_\_\_ describe \_\_\_\_\_

Joint replacement \_\_\_\_\_

Describe \_\_\_\_\_

Pain \_\_\_\_\_ Frequency/Intensity \_\_\_\_\_

Relieved by \_\_\_\_\_

Muscular Disorders \_\_\_\_\_

**Endocrine**

Diabetes \_\_\_\_\_ date of onset \_\_\_\_\_ BGM \_\_\_\_\_

Controlled by: Diet \_\_\_\_\_ Oral

Med \_\_\_\_\_ Insulin \_\_\_\_\_

Describe assistance needed \_\_\_\_\_

Other Endocrine \_\_\_\_\_

**Cardiovascular Disease**

Vital signs: \_\_\_\_\_ peripheral Edema \_\_\_\_\_

High or low blood pressure \_\_\_\_\_

History of MI (myocardial infarction, Coronary artery disease, cardiovascular accident/stroke \_\_\_\_\_

Describe \_\_\_\_\_

**Neurological disease**

Seizure disorder \_\_\_\_\_ paralysis \_\_\_\_\_

Neuropathies \_\_\_\_\_

Other \_\_\_\_\_

**Mental Health Needs/Behavior Interventions**

Alert \_\_\_ Oriented to: Person \_\_\_ Place \_\_\_ Time \_\_\_ Date \_\_\_

Anxious \_\_\_ Forgetful \_\_\_ Depressed \_\_\_ Wanders \_\_\_ Cooperative \_\_\_

Routinely sees a mental health professional \_\_\_ Condition/illness Limits \_\_\_

Behavior Socially Acceptable: Yes \_\_\_ No \_\_\_

Describe \_\_\_\_\_

Responds to Redirections \_\_\_\_\_

**Social Supports**

Satisfied with Quality of Life Yes \_\_\_ No \_\_\_ Family  
Involvement \_\_\_\_\_

Friends/Neighbors \_\_\_\_\_

Community Involvement \_\_\_\_\_

Church membership/involvement \_\_\_\_\_

Hobbies Recreation \_\_\_\_\_

Barriers to pursuing Social Activities \_\_\_\_\_

**Other health Problems** \_\_\_\_\_

**Other Information** \_\_\_\_\_

\_\_\_\_\_

**Questions you may have for the facility** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_