English Version

Buena Vida
Home Health Agency
Phone: 773-875-5879
Fax 312-761-5258
5318 W Devon ave, Suit 6 Chicago il 60646

TIME IN/OUT: _____ **ADMISSION CHEAT SHEET/SOC REPORT**

Patient Name:	SSN:	
Height:	Weight:	(__) Married (__) Single (__) Divorced (__) Widow
PCP:	Last Seen/Next Appt:	Phone:
Emergency Contact:	Relationship:	
Advance Directives: (__) Living Will (__) POA for Healthcare. Name: _____ (__) DNR (__) None; Did you Discuss with Patient? (__) Yes (__) No		
Vital Signs: BP: _____ Temp: _____ HR: _____ RR: _____ BS: _____ Pain Level: Location: Frequency: (__) All the Time (__) Intermittent (__) Occasional		
Medical HX: Primary Reason for HH Admission:	Recent Inpatient Stay: (__) Yes (__) No Facility: DC Date: Reason:	
Vaccines: Flu (__) Not in Season (__) HH to Provide (__) Refused Obtained At: _____ On ___/___ Pneumonia (__) HH to Provide (__) Refused Obtained At: _____ On ___/___		
Social HX: (__) Smoking (__) Obesity (__) ETOH Abuse (__) Drug Dependence	Living Conditions: (__) Cluttered (__) Clean (__) Safe Safety Issue:	
Surgical HX:	Allergies:	
Mental Status: (__) Alert and Oriented: (__) Person (__) Place (__) Time (__) Forgetful (__) Lethargic (__) Able to Answer Simple Yes/No Questions. Does Not Fully Understand Health Issues. (__) Depressed (__) Comatose/Nonresponsive (__) Dementia (__) Other Mental Issues:		
Assistive Device/DME at Home: (__) Cane (__) Walker (__) Rollator (__) Wheelchair (__) Raised Toilet Seat (__) Commode (__) Shower Chair	DME/Supplies Needed:	
Respiratory Equipment: (__) Oxygen (__) CPAP (__) BIPAP (__) Vent (__) Trach	Supplier Name and Phone:	
ADLS: Feeding: (__) Independent (__) Min. Assist. (__) Mod. Assist. (__) Max Assist. Transferring: (__) Independent (__) Min. Assist. (__) Mod. Assist. (__) Unable Ambulation: (__) Independent (__) Cane (__) Walker (__) Wheelchair Toileting: (__) Independent (__) Min. Assist. (__) Mod. Assist. (__) Max. Assist. Grooming: (__) Independent (__) Min. Assist. (__) Mod. Assist. (__) Max. Assist. Meal Preparation: (__) Independent (__) Min. Assist. (__) Mod. Assist. (__) Max. Assist.	GU/GI Appetite: Diet: Incontinence: (__) Bowel (__) Bladder (__) Diapers Last BM:	
Sensory Issues: Vision: (__) WNL (__) Glasses (__) Glaucoma (__) Retinopathy (__) Blind Hearing: (__) WNL (__) HOH	Fall Incidents in the Last 3 Months:	
Other Pertinent Data: (__) left medications list with patient SN Frequency: (__) Per week	Referrals Needed: (__) PT (__) Dietitian (__) OT (__) MSW (__) ST (__) Homemaker (__) Aide (__) Podiatry (__) Visiting MD	

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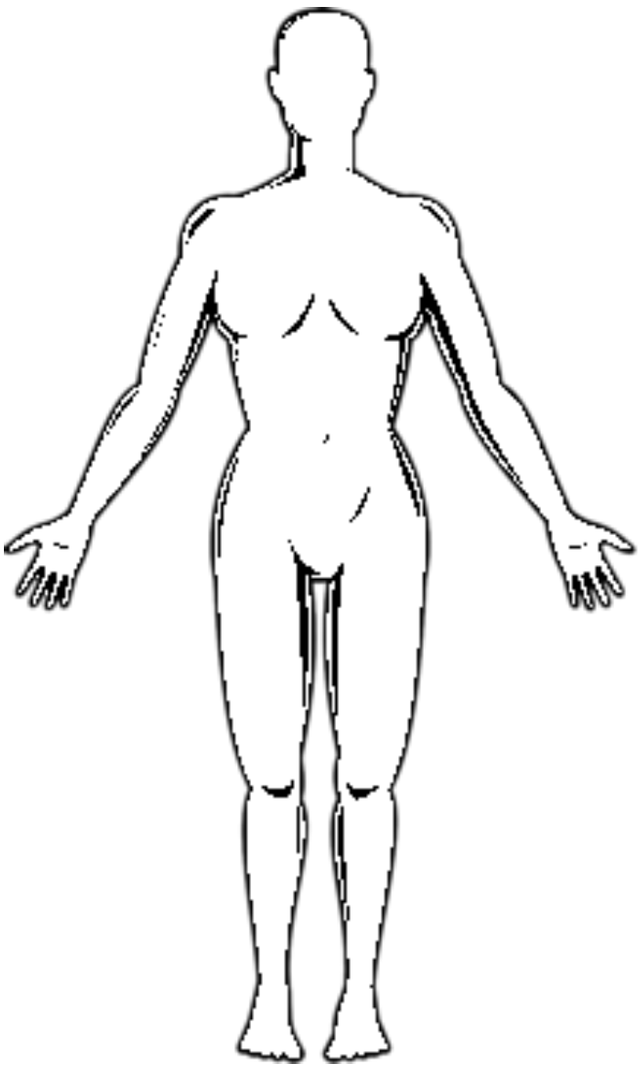
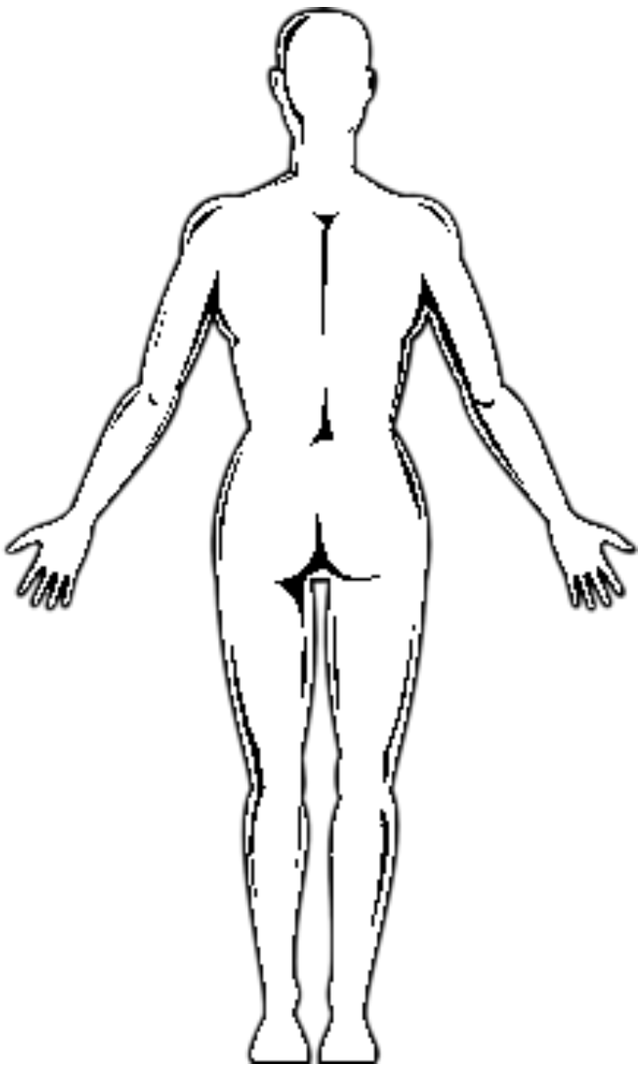
Wound Dressing Protocol: _____

Measurements (cm)

FRONT



POSTERIOR



Medlist: _____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____