

Virosa INC, Central Valley Congregate Living
1051 Tennis Lane Tracy Ca 95376
Phone: 209-740-4483 Fax: 209-879-5400
Lead LVN Wendy Swindle: 209-206-6189
9404

Fair Oaks Residential Tx Facility LLC
7959 Orange Avenue Fair Oaks Ca 95628
Phone: 916-307-0478 Fax: 916-534-7873
Lead LVN Sunpreet Kaur: 916-903-0705

Hayward Residential Tx Facility LLC
1782 B Street Hayward Ca 94541
Phone: 510-951-0780 Fax: 510-363-8001
Lead LVN Rosalie Deering: 510-410-

ADMISSION QUESTIONNAIRE

DATE: _____

PT NAME: _____ DOB: _____

KAISER ID: _____ SS# _____

MEDICAL ID#: _____ HOMELESS? YES NO

PT PHONE # _____ OK TO CONTACT? YES NO

PATIENT IS VOLUNTARY AND AGREES TO PARTICIPATE IN OUR PROGRAM AND ABIDE BY OUR GUIDELINES? PLEASE CIRCLE ONE. IF CONSERVED STATE SO. YES NO

DC PLANNING:

PT CURRENT ADDRESS OR PREVIOUS IF HOMELESS: _____

WILL PT BE RETURNING TO (CURRENT) ADDRESS UPON DISCHARGE? YES NO

RETURNING HOME ALONE? YES NO

IF RETURNING HOME DOES THE PATIENT HAVE FAMILY AND/OR COMMUNITY SUPPORT? YES NO

NAME OF CARE MEMBERS:

_____ PHONE# _____

OK TO CONTACT CARE PROVIDER (S)? YES NO

WILL A HIGHER LEVEL OF CARE POSSIBLY BE NEEDED UPON DISCHARGE? YES NO

IHSS IN PLACE: YES NO IHSS SERVICES NEEDED: YES NO

DOES PATIENT HAVE MEDI-CAL: YES NO IF YES FOR WHICH COUNTY: _____

PATIENTS INCOME: SSI: _____ DISABILITY: _____

RETIREMENT: _____ OTHER: _____

IS PATIENT CONSERVED? YES NO

CONSERVATOR NAME: _____ PHONE#: _____

DOES PATIENT HAVE A PAYEE? YES NO

PAYEE'S NAME: _____ PHONE#: _____

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ADMISSION ADL-DME NEEDS:

HEIGHT: _____

WEIGHT: _____

INDEPENDENT: YES NO DATE OF LAST FALL IF APPLICABLE: _____

ASSISTANCE NEEDED WITH:

BATHING: YES NO DRESSING: YES NO

TRANSFERING: YES NO AMBULATING: YES NO

ASSISTIVE DEVICES USED: _____

DME NEEDS PRIOR TO ADMISSION: _____

COVID VACCINE RECEIVED? _____ MANUFACTURER:

COUNTY RECEIVED: _____

1ST INJECTION DATE: _____ 2ND INJECTION DATE: _____

Booster Date(s): _____

SIDE EFFECTS? _____

DATE OF LAST PPD PLACED: _____ RESULTS: POS NEG CHEST XRAY PROVIDED

RESULTS OF PPD TEST, QUANTIFERON OR XRAY RESULTS INCLUDED WITH REFERRAL? YES NO

(PLEASE INCLUDE ACUTAL COPY WITH DOCUMENTS)

ANY CURRENT INFECTIOUS PROCESS/DISEASE(S)? YES NO IF YES PLEASE LIST TYPE AND

TREATMENT BELOW

ARE CONTROLLED MEDICATIONS BEING ADMINISTERED?

CONTROLLED MED LIST: _____

THANK YOU FOR YOUR ASSISTANCE! THIS INFORMATION IS VERY HELPFUL IN PROPERLY PREPARING FOR AN ADMISSION AND ASSISTS WITH PLACEMENT UPON DISCHARGE IF ASSISTANCE IS NEEDED. IF YOU HAVE ANY FURTHER QUESTIONS FOR OUR STAFF MEMBERS, PLEASE FEEL FREE TO CALL ANYTIME.