Sacred Heart Home

1315 West Hunting Park Avenue
Philadelphia, PA 19140
215-329-3222 FAX: (215-329-4197)
www.sacredheartphila.org

APPLICATION AND PRE-ADMISSION FORM

Please Read All Information Carefully
All Questions MUST Be Answered Before the Application Can Be Reviewed and Processed

The following reports are needed for the application to be complete:

1. **Completed application signed by the physician** ☐
2. **Documented proof of a diagnosis of incurable cancer. This may be a CAT Scan, a Biopsy Report, or other requested information.** ☐
3. **Chest X-Ray *** ☐
4. **Recent history and physical by a physician and/or discharge summaries** ☐
5. **Most recent medication list** ☐
6. **Pertinent lab reports** ☐
7. **DNR order** ☐

*** Also, any relevant scans that are available.**

Sacred Heart Home accepts no payment of any kind, including Medicare, Medicaid, private insurance or private pay.

FINANCIAL NEED IS A REQUIREMENT FOR ADMISSION.

Patients and families must be informed that the care provided by Sacred Heart Home is palliative, not curative. All treatments must be completed before the patient is accepted. Medications and all ancillary orders will be prescribed by our physician.

Do Not Resuscitate – As only persons with incurable cancer are admitted to Sacred Heart Home, and as Sacred Heart Home provides only palliative care, all patients must submit a valid "Do Not Resuscitate" (DNR) Order prior to admission.

Palliative Care is a concept of care which employs medical and nursing care as well as specific ancillary services, when indicated, whose primary objective is the comfort and overall well-being of the incurable/terminal individual. No treatment is employed which would overburden the individual, yet full support is offered for basic physical needs as well as spiritual, psychological and emotional needs. Personalized nursing plans of care, based on individual needs and symptoms, will be developed.

The completed application is reviewed by the Director of Nursing and the Medical Director.

All of the following care can be provided at Sacred Heart Home: tracheostomy, colostomy, and other ostomy care; gastric or other tube feedings; decubitus care, pain management; oxygen; nebulizer treatments; and general palliative care. Ostomy sites of any kind must be present on admission. Ventilators are not used.

A transfer form must accompany the patient on admission if he/she comes from another facility or a list of medications if the patient comes from home.

Our physician will visit the patient once a week and more often if necessary. He is available by telephone.

I AM AWARE OF AND ACCEPT THE POLICIES STATED ABOVE.

Signature of patient/responsible person required for admission.

Signature: _____ Relationship: _____

Name: _____ Home Phone No: _____

(Please Print)

Address: _____ Work Phone No: _____

_____ Cell Phone No: _____

Sacred Heart Home does not discriminate in the admission of patients with regard to race, color, national origin, age, sex, religious creed, handicap or disability. However, it is the policy of the Home to safeguard the health and safety of its residents and to operate the facility without undue disruption of service to the residents and their families. In accordance with this policy, we abide by the following directive from the Pennsylvania Department of Health: "A patient who becomes mentally disturbed after admission and exhibits behavior which may cause injury to himself or others may be treated in the facility by appropriate medical management and supervision. If, in the opinion IV, 201.25 (e) of the attending physician, the patient cannot be managed, immediate arrangements shall be made by the attending physician for the transfer of the patient to an appropriate facility at the earliest practical time. The current facility is responsible for the health and safety of the patient and for arranging the safe and orderly transfer of the patient."

Pennsylvania Code, Title 28, IV, 201.25 (e)

Applicant's Name: _____
Last **First** **Middle**

Date of Birth: _____ **Male** ☐ **Female** ☐
Month/Day/Year

Address: _____ **Race:** _____
Number and Street **Apt. #**

Religion: _____

_____
City, State, and ZIP Code **Marital Status:** _____

Social Security Number: _____ **Height:** _____ **Weight:** _____

Veteran: _____ **Branch of Service:** _____ **Years:** _____ **Ambulatory:** _____
Yes/No

Lived Alone: Yes ☐ **No** ☐

Where is the patient presently? _____

Occupation: _____

Location: _____

Place of Birth: _____

Who is presently caring for the patient? _____

If admitted from home, date of most recent hospitalization: _____

Family/Responsible Person Contacts

*** Please indicate if the person listed as a contact has Power of Attorney or other special legal relationship to the patient.**

Primary Contact

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. # City State ZIP Code

Phone #'s: Home: _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. # City State ZIP Code

Phone #'s: Home: _____ Work: _____ Cell: _____

Nursing Assessment

Applicant's Name: _____ **Age**: _____ **Sex**: _____

1. **Present Mental Status**:
   - ☐ Alert ☐ Disoriented ☐ Noisy ☐ Depressed ☐ Abusive
   - ☐ Oriented ☐ Anxious ☐ Quiet ☐ Withdrawn ☐ Noncompliant
   - ☐ Lethargic ☐ Suspicious ☐ Unresponsive ☐ History of Mental Illness

   Comments: _____

2. **History of Alcohol or Drug Abuse**: (Explain) _____
   _____

3. **Activity/Mobility**:

	Transfers	**Locomotion**
Dependent for all Position Changes ☐	Full Assist ☐	Gerichair ☐
Bedfast ☐	Limited Assist ☐	Wheelchair ☐
OOB to chair ☐	Supervision ☐	Walker ☐
Ambulatory ☐	OOB ad lib ☐	Cane ☐

   Is patient cooperative with personal care? Yes ☐ No ☐

4. **Diet/Nutrition:**
   Type of Diet: _____
   Chewing or Swallowing Problems: _____
   NPO: _____
   Artificial Nutrition (PEG, TPN, PPN, etc.) or Hydration (IV) – Explain: _____
   _____
   Hyperialimentation and IV therapy are not done at Sacred Heart Home.

5. **Communication**: Language Spoken: English ☐ Other ☐ Specify: _____
   Aphasia ☐ Speech Slurred or Garbled ☐ Non-communicative ☐

6. **Special Needs/Applicances/Equipment**:
   - Oxygen (mode of delivery and L/min) _____ Incontinent of Urine ☐
   - Tracheostomy (Size and Make) _____ Foley Catheter ☐
   - Suction ☐ Incontinent of Feces ☐
   - Humidifier ☐ Ostomy ☐ Specify: _____
   - Wound Care (Explain in detail, site, origin, and procedure): _____
   _____
   _____
   - Other Issues/Needs: _____
   _____

7. **Restraints:** (Describe and explain) _____
   _____

8. **Smoking**: Currently Smokes: ☐ Yes ☐ No Packs per day: _____

Nurse/Caregiver Signature: _____ **Telephone Number:** _____
Print Name: _____ **FAX Number:** _____

Medical Summary

Applicant's Name: _____ **Age**: _____ **Sex**: _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

Primary Site of Malignancy: _____ **Date of Onset**: _____

A Pathology Report and/or appropriate scans and lab results supporting the diagnosis **MUST BE ATTACHED**.

Presenting Symptoms: _____

Prognosis/Stage of Illness/Organs Affected: _____

Brief Medical Summary and Course of Treatment: _____

_____

_____

_____

Surgeries: _____

Radiation: _____

Chemotherapy: _____

Hospital where patient was treated: _____

TB Screen: **First Step**: **Date**: _____

Chest X-Ray (Attach Report or Write): _____
Results **Date**

Pneumococcal Vaccine: _____ **Influenza Vaccine**: _____
Date **Date**

H/O Infectious Diseases: _____

List Current Medications: _____

_____

Allergies: _____

Physician's Name: _____
Address: _____
_____
Telephone No: _____
FAX No: _____

_____
Signature of Physician **Date**