APPLICATION FOR PRIVATE PAY ROOM/SUITE

GENERAL INFORMATION

DATE: ______________________ TOURED WITH: _____________________________

RESIDENT INFORMATION:

NAME: _____________________________ DOB: _____________________________________

PHN #: _____________________________ PHONE NUMBER:___________________________

ADDRESS: ____

____

REASON FOR ADMISSION: ____

PREFERRED LOCATION/ ROOM #: ____

LANGUAGE: __________________ MARITAL STATUS: __________________ EDUCATION: _______________

MEDICAL INFORMATION

FAMILY PHYSCIAN: _____________________________ PHONE NUMBER: __________________________

CURRENT MEDICAL CONDITIONS: ____

____

MEDICAL HISTORY: ____

____

COGNITION: ____

DAILY CARE ASSISTANCE NEEDED: ____

DIET: ____ DENTURES: ________________________

ANY ALLERGIES TO FOOD OR MEDICATIONS: ____

ACCOUNTING INFORMATION

NAME OF CARE REPRESENTATIVE: ____

RELATIONSHIP TO THE RESIDENT: ____

PHONE NUMBER: ______________________ E-MAIL: ____

ADDRESS: ____

NAME OF FINANCIAL REPRESENTIATIVE: ____

RELATIONSHIP TO THE RESDIENT: ____

PHONE NUMBER: ____________________ E-MAIL: ____

ADDRESS: ____

Please provide copies of POA, Enduring POA, Representative agreement (7 or 9)

DATE: ___________________________

SIGNATURE: _______________________

CONSENT TO RELEASE INFORMATION

I, ____, hereby give my consent for the release of medical information to Lynn Valley Care Centre for:

NAME: ____

RELATIONSHIP: ___________________________________

DATE: ____

SIGNATURE: ______________________________________