St.Vincent Jennings Hospital

ER Phone #
ER Fax #

GROUP HOME/WAIVER RESIDENT INTAKE FORM

To be taken to medical appointments and to Emergency Room visits.

Resident Name: _____ Date: _____

Chief Complaint: _____

_____

Date of Birth: _____ Last Tetanus: _____

Pneumovax date given: _____ Influenza vaccine: _____

Code Status (attach copy of Advance Directive if available): _____

Allergies: _____

Primary Care Physician name and phone #: _____

Provider Contact Person name and phone #: _____

Is resident competent to consent for medical treatment? *Please circle* ***YES*** ***NO***

If no, please provide Guardian or Healthcare Rep name and phone number:

Guardian/HCRep Name*:* **Phone #***:*

Past Medical & Surgical History:

_____

_____

_____

_____

_____

Current Medications or MAR:

Attach current Medication Administration Record or additional pages if necessary

Medication Name/Strength	Dosage	Route	Directions/Frequency