Heritage Inquiry Form

Date of Inquiry: ______________________________ Time: _______________________________

How did you hear about The Heritage?

____

Do you know anyone who lives at the Heritage? Yes No

Interested in information about (please check):
Independent Living Assisted Living Skilled Nursing Not sure

Potential Resident:

Name: ____

Address: ____ City: ___________________________

State: __________ Zip Code: _____________ Email address: _____________________________

Telephone number: ________________________ Cell phone number: _______________________

Support Person:

Name: ____

Address: ____ City: ___________________________

State: __________ Zip Code: _____________ Email address: _____________________________

Telephone number: _______________________ Cell phone number: ________________________

Needs / Current Status / Notes:

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____

Place of Interest (please circle):
- ☐ Studio Apartment (Community Based Residential Facility) - 370 sq. feet
- ☐ One bedroom Apartment – 625 sq. feet
- ☐ Two bedroom standard Apartment – 900 sq. feet
- ☐ Two bedroom deluxe Apartment – 1150 sq. feet
- ☐ Two bedroom suite Apartment – 1250 sq. feet

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ADMISSION COORDINATOR, ADMINISTRATOR OR NURSING SUPERVISOR ONLY WILL ASK THESE QUESTIONS:

Have you been hospitalized within the past 3 months? **Yes No**
If yes, what was your Diagnosis?____

Does family ever express concern for your health or safety? If so with what are they concerned? ____

Are you currently living in a licensed facility or have lived in a licensed facility within the last 6 monhts? **Yes No**

Have you had a stroke or TIA within the past 6 months? **Yes No**

Have you fallen within the past 6 months? **Yes No**

Have you had a fall resulting in an injury? **Yes No**

Have you experienced a decline in memory functioning, confusion, or mental status changes such as; unusual thinking or seeing things others don't see, in the last 6 months? **Yes No**
If yes, please explain: ____

Have you wandered (not aware of where you were going) in the past 6 months? **Yes No**
If yes, please explain: ____

Have you woken up at night thinking it was morning? **Yes No**

Have you been diagnosed with Diabetes? **Yes No**

Are you taking Coumadin or Warfarin? **Yes No**

Are you taking any medications for Dementia or to help you remember better (Aricept, Exelon Patch, Namenda)? **Yes No**

Do you use oxygen for breathing on a daily basis or as needed? **Yes No**

Are you limited in your mobility for walking long distances because of shortness of breath or pain? **Yes No**

Do you have a loss of urinary or bowel functioning or indwelling catheter? **Yes No**

Does anyone; such as family or hired help, assist you with bathing, dressing, medications or housekeeping? **Yes No**

Do you currently receive any home care services? **Yes No**
If yes, what services and how often? ____
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Do you currently receive any care services from a family member? **Yes** **No**

If yes, what services and how often? ____

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Do you have an activated POA? **Yes** **No**

Is there any other clinical information that you think we should know about?

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