

**OUR LADY OF GOOD COUNSEL HOME  
2076 ST. ANTHONY AVE., ST. PAUL MN 55104  
TELEPHONE 651-646-2797 FAX 651-646-7884**

Our Lady of Good Counsel Home is a skilled nursing facility for incurable cancer patients who cannot afford the care they need. All treatment for the cancer must be completed prior to admission. The Home is supported entirely by the donations of a generous public.

This facility does not discriminate because of race, color, creed, sex, age, handicap, national origin or sexual orientation. A hospice assessment will be preformed upon admission.

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
First Middle Last (Maiden)

ADDRESS \_\_\_\_\_  
Street City County State Zip

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ RACE \_\_\_\_\_ RELIGION \_\_\_\_\_

BIRTHPLACE \_\_\_\_\_ PHONE # \_\_\_\_\_  
City County State

MEDICARE NUMBER (IF AVAILABLE) \_\_\_\_\_

MEDICAID ELIGIBLE YES NO PENDING

MARITAL STATUS \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

COMPLETE DIAGNOSIS \_\_\_\_\_

PRIMARY SITE \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

PROGNOSIS \_\_\_\_\_

BRIEF HISTORY \_\_\_\_\_

OTHER  
DIAGNOSES \_\_\_\_\_

MENTAL STATUS \_\_\_\_\_

CONTAGIOUS OR COMMUNICABLE DISEASE \_\_\_\_\_

ALLERGIES \_\_\_\_\_

HOSPITAL WHERE PATIENT WAS TREATED \_\_\_\_\_

PATIENTS'S CURRENT LOCATION \_\_\_\_\_

ACTIVITY LEVEL: COMPLETE BED PATIENT \_\_\_\_\_ AMBULATORY \_\_\_\_\_ CHAIR \_\_\_\_\_  
DIET: REGULAR \_\_\_\_\_ SPECIAL \_\_\_\_\_ TUBE FEEDING \_\_\_\_\_ TYPE \_\_\_\_\_  
ELIMINATION: CONTINENT \_\_\_\_\_ INCONTINENT \_\_\_\_\_ FOLEY CATHETER \_\_\_\_\_  
PATIENT'S APPROXIMATE WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_  
LEVEL OF CONSCIOUSNESS: ALERT \_\_\_\_\_ LETHARGIC \_\_\_\_\_ COMATOSE \_\_\_\_\_  
COMMUNICATION: ABLE TO SPEAK \_\_\_\_\_ SPEAKS ENGLISH \_\_\_\_\_ OTHER \_\_\_\_\_  
CURRENT MOOD/BEHAVIOR: DEPRESSED \_\_\_\_\_ CONFUSED \_\_\_\_\_ NOISY \_\_\_\_\_ QUIET \_\_\_\_\_  
PSYCHOTIC \_\_\_\_\_ SUSPICIOUS \_\_\_\_\_ BELLIGERENT \_\_\_\_\_ ALCOHOLIC \_\_\_\_\_  
OTHER COMMENT \_\_\_\_\_  
SPECIAL SUPPLIES/EQUIPMENT NEEDED: OXYGEN \_\_\_\_\_ SUCTION MACHINE \_\_\_\_\_  
HUMIDIFIER \_\_\_\_\_ SPECIAL MATTRESS \_\_\_\_\_ TRACH TUBE \_\_\_\_\_  
COLOSTOMY \_\_\_\_\_ OTHER \_\_\_\_\_  
NAME OF HOSPICE IF APPLICABLE \_\_\_\_\_ START DATE \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
PRIMARY DOCTOR \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
RESPONSIBLE PARTY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
SECOND PERSON \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
SOCIAL WORKER \_\_\_\_\_ PHONE \_\_\_\_\_

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**REQUIREMENT FOR ADMISSION: DO NOT RESUSCITATE/DO NOT INTUBATE STATUS, APPLICATION SIGNED BY PHYSICIAN AND ATTACH THE FOLLOWING DOCUMENTS: MOST RECENT MEDICATION LIST, RECENT HISTORY AND PHYSICAL, PATHOLGY REPORT, CHEST X-RAY REPORT (WITH IN 3 MONTHS OF ADMISSION),**