

**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),