New Resident Information File

Thank you for choosing Golden Brook for the care of your loved-one. We appreciate your confidence in Golden Brook to provide the best memory care available.

Please complete the following information for our records.

RESIDENT INFORMATION

Name: ______________________________

Date of Birth: ______________________________

Height: ______________ Weight: ______________

Social Security: ______________________________

Religious Preference: ______________________________

Active DNR: YES NO Please provide copy, if yes

PHYSICIAN INFORMATION

Physician Name ______________________ Specialty: ______________

Phone #: ______________________________

Physician Name ______________________ Specialty: ______________

Phone #: ______________________________

Physician Name ______________________ Specialty: ______________

Phone #: ______________________________

Dentist Name ______________________ Specialty: ______________

Phone #: ______________________________

GENERAL RESIDENT INFORMATION

Hobbies: ______________________________

____

Past Occupation/Trade: ______________________________

General Likes/Dislikes: ______________________________

____

____

RESIDENT DIET HISTORY

1. Have you been on a special diet within the past 60 days?

   ___ Yes ___ No If so, what kind?

   ____

2. Are there any foods you cannot eat due to allergies/discomfort? _______________________

   ____

3. Do you have any religious restrictions regarding food? ______________________________

   ____

4. What beverages do you like with your meals?

   Breakfast: ____

   Lunch ____

   Dinner ____

5. What are your favorite meals? (Circle each)

   Roast Beef Veal Beef Stew Tuna Pork Ham Sausage Salmon

   Chicken Pork Chops Turkey Corned Beef White Fish Crab Cakes

   Ground Beef Other ____________________________________

6. Do you have difficulty chewing or swallowing? Yes _____ No_____

7. What are your favorite vegetables? (Circle each)

   Broccoli Brussel Sprouts Spinach Corn Lima Beans

   Cabbage Green Beans Carrots Cucumbers Zucchini Tomatoes Wax Beans

   Cauliflower Other ____________________________________

8. Do you like fruit? Yes ___ No ___ Favorites ____________________________

9. Do you like soups? Yes ___ No ___ Favorites____________________________

10. Which of the following starches do you like? (Circle each)

    Pasta Rice Yams Baked Potatoes Boiled Potatoes

    Noodles Sweet Potatoes Other ______________________________________

11. Do you drink the following juices? (Circle each)

    Orange Prune Tomato Apple Grapefruit Cranberry

    V-8 Other ____

12. Do you eat the following cheeses? (Circle each)

    Cottage American Swiss Cheddar Other __________________

13. Do you enjoy desserts? (Circle each)

    Pie Ice Cream Sherbet Other ______________________________________

RESIDENT ID CARD

FRONT OF CARD

RESIDENT ID CARD

BACK OF CARD

HEALTH INSURANCE ID CARD

FRONT OF CARD

HEALTH INSURANCE ID CARD

BACK OF CARD

COVID-19 VACCINATION CARD - FRONT OF CARD

COVID-19 VACCINATION CARD - BACK OF CARD

RESIDENT MONEY AND PROPERTY NOTICE

This facility will not be responsible for money or personal property. We recommend that the Resident keeps no money in the facility at any time. No employee shall keep any personal belongings or money for any Resident.

The Residential Facility Administrator, owner or staff shall not accept appointment as guardian or conservator of the estate of any Resident, become a substitute payee for any payments made or accept an appointment as attorney in fact for any Resident.

NO MONEY WILL BE HELD BY THIS FACILITY ON BEHALF OF ANY RESIDENT. NO RESIDENT SHALL LEND MONEY TO AN EMPLOYEE OF THIS FACILITY.

__________________________________ _______________
Resident/Responsible Party (Signature) Date

__________________________________ _______________
Resident/Responsible Party (Printed Name) Date

__________________________________ _______________
Golden Brook Date

MEDICATION SUPERVISION AUTHORIZATION

I authorize Golden Brook to retain and supervise the administration of my medications.

______________________________	______________
Resident/Responsible Party (Signature)	Date
______________________________	______________
Resident/Responsible Party (Printed Name)	Date

NEGATIVE COVID-19 TEST

I will supply a NEGATIVE COVID-19 test 3-days prior to move-in to the Golden Brook Care Home.

________________________________ ______________
Resident/Responsible Party (Signature) Date

________________________________ ______________
Resident/Responsible Party (Printed Name) Date

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

I authorize Golden Brook Residential Facility to receive and/or disclose my protected health information as outlined below:

- Golden Brook is allowed to receive all medical information from any doctor, hospital, clinic or other person/facility who has provided medical services to me within the last year.
- Golden Brook is allowed to disclose my personal medical information to the following:

____

____

____

This medical information may be used by the person I authorize to receive this information for medical records, admission requirements, file copies or other purposes as I may direct. This authorization shall be in force and effect until the last day of Residency at Golden Brook or when terminated by myself or my Responsible Party, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand that my Admission to the Facility will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ________________

Signature of Resident or Responsible Party Date

____

Printed Name of Resident or Responsible Party

Move-in Checklist

Facility Provided

Room Furnishings

- Television
- Chair
- Trash Can
- Dresser
- Room Décor
- Table light
- Nighlight

Bedding

- Twin bed sheets – two sets
- Comforter – two
- Pillows - two
- Pillowcases – four
- Mattress pads – two
- Mattress protector – two

Towels

- Bath towels - four
- Wash cloths - four
- Face towels - four

Toilet/bathroom supplies

- Shampoo
- Toothpaste
- Powder
- Body lotion
- Tissues
- Hand soap
- Toothbrush

Common Area

- Television
- Common area telephone
- Laundry soap - Tide

Family Provided - if desired

Room Furnishings

- Personal phone
- Personal photos/pictures for wall
- Collectibles (no sharp or glass please)

Bedding

- Heating blanket
- Personal bedding

Towels

- Anything personal

Toilet/bathroom supplies

- Electric razor only
- Hair brush/comb
- Personal soap
- Continence supplies – briefs/depends, gloves, chucks, baby wipes - we offer a Continence program for convenience as an add-on

Clothing

- At least seven days of clothing
- Underwear/undergarments - seven
- Sweaters
- Coats
- Shorts - four pair
- T-shirts - seven
- Night gowns/pajamas - four
- Bathrobe - two
- Slippers
- Comfortable Shoes/sneakers
- Sweat pants - two
- Special laundry soap for allergies