PRELIMINARY APPLICATION FOR ADMISSION TO S.T.R.I.V.E.

Please complete the following items as fully as possible and return this form to:

COORDINATOR OF ADMISSIONS – S.T.R.I.V.E.
415 A STREET
PROPHETSTOWN, ILLINOIS 61277
PH (815) 537-5358

Date of Application________________________________

________________________ ________ ________________________
Last Name Middle Name Last Name

____________________ ______________________ ______________________
Date of Birth Social Security County

______________________________ ________________ _______ _________
Street/P.O. Box City State Zip Code

_____________________ _________ _____ _________________
Language Sex Race Marital Status

____
Phone Number

____
Diagnosis/Disability

______________________________ __________ ________________________
Name of Contact/Next of Kin Relationship Phone Number (home)

______________________________________ ________________________
Street/P.O. Box Phone Number (work)

_________________________ ______________ _______________
City State Zip Code

Own Legal Guardian? Yes or No
If No, please list: Guardian Name____
Address____
Phone Number_____________________________________

NAME OF APPLICANT____

_______________________________________ _________________________________
Name of Physician Phone Number

____
Street Address

______________________________ _____________ _____________
City State Zip Code

MEDICAL INFORMATION

PLEASE READ THOROUGHLY AND CHECK (X) APPLICABLE INFORMATION

MOBILITY:

_____ manual wheelchair; self-propelled
_____ manual wheelchair; needs assist
_____ electric wheelchair; self-propelled
_____ electric wheelchair; needs assist
_____ needs assistance with transfers
_____ walker
_____ walker with assist
_____ total assist for mobility
_____ other (specify) ____________________

CONTRACTURES:

_____ none _____ arm _____ foot
_____ hand _____ leg _____ history of contractures

SKIN CONDITION:

_____ good _____ decubitus _____ abrasions
_____ broken areas _____ history of decubiti

BLADDER:

_____ independent in toileting
_____ requires assist for toileting
_____ totally dependent for toileting needs
_____ incontinence pads
_____ continent
_____ incontinent
_____ catheter (specify type & size)
____

BOWEL:

_____ regular _____ frequent laxatives _____ suppositories
_____ incontinent _____ enemas _____ subject to impaction

OSTOMY CARE:

_____ jejunostomy _____ ileostomy _____ colostomy

NAME OF APPLICANT____

APPLIANCES:

_____ hearing aid _____ augmentative communication device
_____ glasses _____ alphabet board
_____ brace (specify)____
_____ prosthesis _____ splints (specify)____
_____ ADL adaptive equipment (specify)____
_____ other ____

BATHING/DRESSING/PERSONAL HYGIENE:

_____ self-care _____ total care _____ needs assistance

If assistance is necessary, please specify:____
____
____

ALLERGIES:

_____ none _____ other (specify)____
____

DIET/EATING:

_____ general diet _____ unimpaired swallowing _____ dysphagia
_____ cannot feed self _____ diabetic _____ gastrostomy/J-tube
_____ NPO _____ insulin-dependent diabetic
_____ NG tube _____ tracheostomy; needs suctioning
_____ tracheostomy; does not need suctioning
_____ special diet (specify)____

SPEECH:

_____ normal _____ speech is difficult to understand
_____ non-verbal _____ unintelligible speech
_____ impaired rate of speech
_____ uses electro-larynx or alaryngeal speech (specify)_______________________________
____

CONGNITION/COMPREHENSION:

_____ alert _____ disoriented _____ slow thought processing
_____ confused _____ memory impairment
_____ difficulty with judgment, reasoning or problem-solving

If any area other than “alert” is checked please comment:
____
____

NAME OF APPLICANT__________________________________

MEDICATIONS:

_____ able to self-medicate
_____ needs assist to self-medicate
_____ needs total supervision to medicate

Please list medications (including dosages) that you are currently taking:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

ADDITIONAL INFORMATION:

____
____
____
____
____