Print and fill out by hand

**OR** fill out on Computer:

* Save to your Computer
* Type information into the shaded areas.
* To mark a box, click on it with your mouse or tab to it and press the space bar.
* Save changes, print out and fax with the referral packet.

# North Carolina’s

**Department of Health & Human Services**

**Division of State Operated Healthcare Facilities**

**Neuro-Medical Treatment Centers**

**NEURO-MEDICAL TREATMENT CENTER ADMISSION APPLICATION**

**Black Mountain**

Alzheimer’s Program Intellectual/Developmental Disability Program/Specialized Long Term Care

**Longleaf**

Alzheimer’s Program  General Unit

**O’Berry**

Intellectual/Developmental Disability Program / Specialized Long-term Care  Respite  ICF/MR

**Applicant Identifying Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | |
| First Middle and Last Name | | | | | | | |
|  | | | |  | |  | | | |
| Preferred Name | | | |  | | Maiden | | | |
|  |  |  |  | |  | |  | |  | |
| Date of Birth |  | County Of Birth |  | | City Of Birth | |  | | State Of Birth | |
|  |  |  |  | |  | |  | | Yes  No | |
| Social Security Number |  | Medicare Number |  | | Medicaid Number | |  | | Medicaid # Approved | |

#### Current Living Situation

Please list current residence/placement, prior facilities & hospitalizations, with dates of admission. Summarize if needed (i.e. Cherry Hospital, 6 admissions, 1995 – 2011) but give specific dates of most recent psychiatric admission, if applicable.

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#### Legal Status

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If adjudicated incompetent, date North Carolina guardianship qualified: | | | | | | |  | | |
| General | | | Guardian of Person | | Guardian of Estate | | |
| Name of Guardian | | |  | | | | | | | |
| Address | | |  | | | | | | | |
| Phone Number (s) | | (   )       / (   ) | | | Relationship to Applicant: | | |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If legally competent, type of North Carolina Registered Power of Attorney? (Check Which) | | | | | | | | | | | | | | | | | |
| General | | | | | Durable | | | Financial | | | |
| County Registered In | | | | | |  | | | | | | | | | | | |
| Date Registered | | | | | |  | | | | | | | | | | | |
| Name of Power of Attorney | | | | | |  | | | | | | | | | | | |
| Address | | | | | |  | | | | | | | | | | | |
| Phone Number | | | | (   ) | | | | | Relationship to Applicant: | | | |  | | | | |
| Responsible Party (if no Guardian or Power of Attorney): | | | | | | | | | | | | |
| Name | | | |  | | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | | |
| Phone Number | | | | (   ) | | | | | Relationship to Applicant: | | | |  | | | | |
| Advance Directives (please check all that apply) | | | | | | | | | | | | |
|  | Living Will | | | Date: | |  | | |  | | Health Care POA | | Date: | |  | |
|  | Portable DNR | | | Date: | |  | | |  | | MOST | | Date: | |  | |

#### Pre-needs Arrangements:

##### Reason seeking admission (please briefly explain)

#### Family Information

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Marital Status | | | | Single  Divorced  Widowed | | | | | | | | | | |
| # of Years if Married | | | | | | |  | | | | | | | | | |
| Spouse’s Name | | | | | | |  | | | | | | | | | |
| Address (if living) | | | | | | |  | | | | | | | | | |
| Name/Contact Number of involved family members | | | | | | |  | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | |
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|  | | | | | | |  | | | | | | | | | |
| **1. Family History** | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  |
| Father’s Name: | |  | | | | | | | | | | | | | |  |
| Date of Birth: | | |  | | | | | | | Occupation: | |  | | | |  |
| Address: | |  | | | | | | | | | | | | | |  |
|  | (   ) | | | | | | |  | | (   ) | | |  | (   ) | |  |
|  | Home Phone Number | | | | | | |  | | Cell Phone Number | | |  | Work Phone Number | |  |
|  | | | | | | | | | | | | | | | |  |
| Mother’s Maiden Name: | | | | |  | | | | | | | | | | |  |
| Date of Birth: | | |  | | | | | | | Occupation: | |  | | | |  |
| Address: | |  | | | | | | | | | | | | | |  |
|  | (   ) | | | | | | |  | | (   ) | | |  | (   ) | |  |
|  | Home Phone Number | | | | | | |  | | Cell Phone Number | | |  | Work Phone Number | |  |
|  | | | | | | | | | | | | | | | |  |
| Parent’s Marital Status:  Married  Unmarried  Separated  Divorced  Widowed | | | | | | | | | | | | | | | |  |
| ***Siblings:*** | | | | | | | | | | | | | | | | |
| Name | | | | | | Sex | | | **Age** | | **Health Problems** | | | | | |
|  | | | | | |  | | |  | |  | | | | | |
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#### Diagnoses (include all applicable)

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| --- | --- | --- | --- |
| **E. Additional Relevant Neuro-Medical Information**  Brain Imaging Studies (CAT Scan, MRI, PET Scan) | YES  NO | Date: |  |

#### Allergies (Medications, Neuroleptic Malignant Syndrome (NMS), Bee Sting, Etc.)

|  |  |
| --- | --- |
| ALLERGIC TO | DESCRIBE REACTION |
|  |  |
|  |  |
|  |  |
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#### Other Medical Information

|  |
| --- |
| **1. SEIZURE FREQUENCY**  None  Unknown  Less than 1 Per Year  3-6 Per Year  Monthly  Weekly  Daily  More than 1 per day Type: |
| **2. MENSTRUAL PATTERN**  Not Applicable  Regular Frequency:  Pain Describe:  Other Issues: |
| 1. **MEDICATION PROFILE** (list medications and dosages)   Pill  Liquid  Crushed  Other: |
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| Prescription Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **PRIOR HOSPITALIZATIONS**   Date Hospital Reason |
|  |
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#### Skills and Activities of Daily Living

|  |
| --- |
| 1. **LEVEL OF INTELLECTUAL DISABILITY**  Not Applicable   Mild  Moderate  Severe  Profound  Unknown |
| 1. **AMUBLATION SKILLS**   Ambulatory  Non-Ambulatory/Mobile  Non-Ambulatory/Non-Mobile  Crawls  Walks with Assistance |
| 1. **MOBILITY AIDS**   Wheelchair  Walker  Gait Belt  Cane  Crutches  Braces  Stroller |
| 1. **VISION**   Normal  Impaired  Legally Blind  No Vision  Undetermined  Wears Glasses |
| 1. **HEARING**   Normal  Mild Loss  Moderate Loss  Severe Loss  Undetermined |
| 1. **EXPRESSIVE LANGUAGE**   Verbal Language:  Sentences  Phrases  Single Words  Formal Sign Language  Symbol Communication  Informal Gestures  Vocalizes to express needs  Non-verbal/vocal |
| 1. **RECEPTIVE LANGUAGE**   Comprehends many words  Comprehends some words  Attends to gestures or auditory cues  Does not respond to gestural or auditory stimuli |
| 1. **DRESSING**   Completely dresses self, no prompting  Dresses self with verbal prompting only  Pulls off or puts on some items with verbal prompting  Dresses self with extensive physical, gestural and verbal prompting  Cooperates when being dressed by extending limbs  Must be dressed completely  Special clothing needs (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **TOILETING SKILLS**   **Continence**  Independently toilets self  Never has accidents  Has accidents during the day  Has accidents at night  Uses toilet with cues and assistance  **Incontinence**  Uses Incontinence briefs  Uses panty liners |
| 1. **MEALTIME SKILLS**   Sucking, chewing, swallowing is developed  Sucking, chewing, swallowing is delayed  Uses utensils neatly  Uses utensils with spillage  Uses spoon neatly  Uses spoon with spillage  Feeds self with fingers  Feeds self using adaptive equipment  Drinks from a cup, unassisted  Drinks from a cup, assisted  Sits at a table for meals  Sits in a chair with a tray for meals |
| 1. **DIET**   Regular  Chopped  Pureed  Liquid  Feeding Tube  Food Dislikes: :  Food Allergies: : |
| 1. **SLEEPING HABITS**   **Bed**  Regular  Side Rails  Other:  Sleeps through the night  Naps during the day  Climbs out of bed  Sleeps Alone  Uses Pillow  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **LEISURE SKILLS**   **Interests**  Music  TV Objects Outdoor Activities  Swimming  Sports Animals Groups Privacy  Other:  List preferred objects: :  Religious Preference: |
| 1. **SOCIALIZATION SKILLS**   Participates in groups  Initiates interactions with adults  Responds to adults Initiates interactions with children  Responds to children Other: :  Describe relationship with family members: : |
| 1. **EDUCATION/VOCATION**   Highest Grade Completed: :        Special Education Attends Workshop  Prevocational Activities  Worked outside the home Occupation: :  Veteran:  Yes  No Branch: : |

#### Behavioral Concerns

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BEHAVIOR | | FREQUENCY | | DATEs | | **CIRCUMSTANCE** |
| *Example: Hitting* | | *3 episodes total* | | *5/6, 5/9, 5/11* | | *hit peer, hit CNA, hit family member* |
| Hitting | |  | |  | |  |
| Grabbing | |  | |  | |  |
| Kicking | |  | |  | |  |
| Pinching | |  | |  | |  |
| Biting | |  | |  | |  |
| Scratching | |  | |  | |  |
| Hair Pulling | |  | |  | |  |
| Cursing | |  | |  | |  |
| Disrobing | |  | |  | |  |
| Resists ADL Care | |  | |  | |  |
| Wandering | |  | |  | |  |
| Loud Vocalizations | |  | |  | |  |
| Intrusive | |  | |  | |  |
| Threatening Others | |  | |  | |  |
| Pilfering | |  | |  | |  |
| Sexual Behavior | |  | |  | |  |
| **Please List Others Behaviors Below:** | | | | | | |
|  |  | |  | |  |  |
|  |  | |  | |  |  |
|  |  | |  | |  |  |
|  |  | |  | |  |  |

#### Psychotic Symptoms

|  |  |  |
| --- | --- | --- |
| A. Delusions | YES  NO | |
| If “Yes”, describe: | |  | |
| B. Hallucinations | YES  NO | |
| If “Yes”, describe: | |  | |
| C. Psychiatric Evaluation | YES  NO | |
| If “Yes”, date of evaluation: | |  | |

#### History of Substance Use

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SUBSTANCE | YES | NO | **AGE STARTED** | **FREQUENCY AMOUNT** | **LAST USED** | |
| Alcohol |  |  |  |  |  | |
| Cigarettes/Tobacco |  |  |  |  |  | |
| Drugs |  |  |  |  |  | |
|  |  | | | | |
| List Drugs Used: |  | | | | | | |

#### Risks

##### Potential for Falls

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Has applicant fallen within the past 6 months? | | | | | **YES  NO** |
| If injured, date of injury: | |  | | | |
| Please Describe: |  | | | | |
| Ambulation Status: Steady Gait  Assistive devices required | | | | **YES  NO**  **Wheelchair**      (type) **Walker  Cane  Gait Belt  Other** | |
| Specialized positioning needs | | |  | | |
|  | | | |  | |

##### Nutritional Screen:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Height** | |  | | | | **Weight** | | | |  | | |  | | | | | |
| Has there been a significant weight change? | | | | | | | | | **GAIN  LOST** | | | | | | | # of lbs. |  |  |
| Time Period | | | | |  | | | | | | | | | | | | | |
| Poor appetite 10 days or greater? | | | | | | | | **YES  NO** | | | | | | | | | | |
| Swallowing problems? | | | | | | | | **YES  NO** | | | | | | | | | | |
| Swallowing Study? | | | | | | | | **YES  NO** | | | | Date: | | |  | | |  |
| Results Please Describe: |  | | | | | | | | | | | | | | | | | |
| Current Diet | | |  | | | | | | | | | | | Consistency: | | |  | |
| Feeds Self? | | | | | | | **YES  NO** | | | |  | | | | | | | |
| Adaptive Equipment Used? | | | | | | | **YES  NO** | | | |  | | | | | | | |
| Please describe: | | | |  | | | | | | | | | | | | | | |

# 3. Other devices/aids

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Glasses | | | **YES  NO** | |
| If Lost: | Where? |  | | |
|  | When? |  | | |
| Dentures | | | **YES  NO** | |
| Uppers? | | | **YES  NO** | |
| Lowers? | | | **YES  NO** | |
| If Lost: | Where? |  | | |
|  | When? |  | | |
| How long has it been since last wore dentures? | | | |  |
| Hearing Aid? | | | **YES  NO** | |
| If Lost: | Where? |  | | |
|  | When? |  | | |
| Prosthesis Please Explain | | |  | |

# 4. Special precautions: none 1:1 constant visual observation restraints other

|  |  |
| --- | --- |
| Describe/explain reason for precautions: |  |

##### 5. Immunization: Please check vaccines/tests given

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Immunization Given?** | | | | | |  | |  |
| **Immunizations** | | **No** | | **Unknown** | | **Yes** | | **If Yes, Date Given** | |  |
| Flu Vaccine | |  | |  | |  | |  | |  |
| Pneumo Vaccine | |  | |  | |  | |  | |  |
| Tetanus Vaccine | |  | |  | |  | |  | |  |
| Hepatitis B Vaccine | |  | |  | |  | |  | |  |
|  |  | | Results | | | | If positive, chest  x-ray results: | |  | |
| **TB Test:** | Date Given | | Positive + | | Negative - | |
|  |  | |  | |  | |

#### Current Physician

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **City, State, ZIP** |  |
| **Phone Number** | (   ) |

#### Current Dentist

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **City, State, ZIP** |  |
| **Phone Number** | (   ) |

I hereby request admission & treatment at (check one):

Black Mountain Neuro-Medical Treatment Center

Longleaf Neuro-Medical Treatment Center

O’Berry Neuro-Medical Treatment Center

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | |  |  | |
| Person Making Application / Relationship | | |  | Date | |
|  |  |  | | |
| Phone Number |  |  | | |

In the event there is not an appropriate vacancy at the facility selected above, I hereby authorize submission of this application to **Black Mountain Neuro-Medical Treatment Center** (one of the neuro-medical treatment centers listed above).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | |  |  | |
| Person Making Application / Relationship | | |  | Date | |
|  |  |  | | |
| Phone Number |  |  | | |

# Please attach the following information…

1. Provide a separate authorization to disclose health information (document available on web site to print) for each health care provider that has pertinent health information on this applicant. Also include telephone numbers and fax numbers if possible.
2. Current FL-2 (must be approved by HP Enterprises if Medicaid)
3. Copy of this month’s MAR including any PRN medications
4. Most recent History and Physical or admission H&P if in hospital
5. If in hospital current MD progress notes covering current stay
6. If in LTC previous 4-6 months of MD progress notes
7. Nurses notes (2 weeks minimum)
8. Falls Record
9. Most recent Labs
10. Immunization Record
11. PASARR
12. Psychosocial Assessment
13. Brain Imaging Report(s) (CAT Scan, MRI, PET Scan if available)
14. Psychiatric evaluation (if available)
15. Registered Power of Attorney or Guardianship Papers.
16. Advance Directives (if they have any)  
    Health Care Power of Attorney  
    Living Will  
    Portable DNR

###### MOST

Please fax to O’Berry Neuro-Medical Treatment Center’s Admission Office at **919-581-4413.**

OR mail to:

Admissions Office

O’Berry Neuro-Medical Treatment Center

400 Old Smithfield Rd.

Goldsboro, NC 27530

**Should you have any questions regarding the admission process please call the Admissions Office at 919-581-4652.**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Medical Record #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client SS #\_\_\_\_N/A\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize

*(Client or Personal Representative)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to disclose specific health information

*(Name of Provider/Plan)*

from the records of the above named client to: \_\_ O’Berry Neuro-Medical Treatment Center 400 Old Smithfield Road Goldsboro, North Carolina 27530-8464 Office (919) 581-4652 Fax (919) 581-4413 *(Recipient Name/Address/Phone/Fax)*

for the specific purpose(s): continuity of medical care and treatment and/or establish appropriateness of admission to O’Berry Neuro-Medical Treatment Center\_

Specific information to be disclosed: medical information including, but not limited to, physicians notes, consultations, lab and radiology reports, immunization records, medication history, history and physical reports.

I understand that this authorization will expire on the following date, event or condition: one year from date signed below

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol

abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *(Signature of Client)* |  | *(Date)* |  | *(Witness-If Required)* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *(Signature of Personal Representative)* |  | *(Date)* |  | *(Personal Representative Relationship/Authority)* |

*\*\*\*\*\*\*\*\*\*\**

|  |  |  |  |
| --- | --- | --- | --- |
| *NOTE: This Authorization was revoked on* |  |  |  |
|  | *(Date)* |  | *(Signature of Staff)* |