Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
ELEANOR SLATER HOSPITAL
Admissions Department
111 Howard Avenue
Cranston, RI 02920

Office – 401-462-3433
Fax – 401-462-6958
Date: _____

APPLICATION FOR ADMISSION

Name of Applicant:_____

Residence:_____

Date of Birth:_____Married: _____ Ethnicity: _____

Gender: □ Male □ Female Registered Voter: □ Yes □ No U.S. Citizen: □ Yes □ No Religion: _____

Language Preference: _____ Interpreter Needed: □ Yes □ No

REFERRAL SOURCE:

_____

Provider Name Address

_____

Contact Name Contact Phone Number

FAMILY/OTHER SUPPORTS INVOLVED: ☐ Yes ☐ No

_____

Name Address

_____

Contact Number Relationship

INCLUDE PHOTOCOPIES OF ALL MEDICAL COVERAGE CARDS (Front and back)

Social Security #:_____ Name of insured, if other than applicant: _____

Medicare #:_____ Federal □ Medicare Replacement Plan (HMO) □ Agency:_____

If supplemental plan to Medicare please specify:_____ ID #:_____

Medical Assistance #:_____ Other: _____

If pending, list name and contact number of office/worker (RI only) _____

DIAGNOSES/PROBLEMS:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

MEDICATIONS: (including Dose & Route) TPN and IV

_____ _____

_____ _____

_____ _____

Medication Allergies:

_____ _____

ESH – 303 Rev. 3/16, 1/17, 10/18

Clinical rationale for long-term hospitalization:

History of previous treatment and placements:

Describe alternative referrals made and the outcome:

Anticipated discharge goal following long-term care: ☐ Home alone ☐ Assisted living ☐ Nursing home

☐ Home with family ☐ Group home ☐ Other (Please specify): _____

RECOMMENDED SERVICES: ***To be completed by physician, nurse, or case manager*** – please check appropriate boxes.

☐ PT (Describe):_____ ☐ Respiratory / Ventilator:_____

☐ OT (Describe):_____ ☐ Skin / wound care:_____

☐ Speech (Describe):_____ ☐ Other:_____

ACCESS/OSTOMY	**MEMORY**	**COMMUNICATION**	**SENSORY**
☐ NG/G/J Tube	☐ Normal	☐ Normal	☐ Hearing impairment
☐ IV/IV access	☐ Mildly impaired	☐ Language barrier	☐ Vision Impairment
☐ Trach	☐ Moderately impaired	☐ Comprehends	**CONDITIONS**
☐ Ostomy	☐ Severely impaired	☐ Able to relate needs	☐ Pressure sores/wound care
		☐ Aphasic/non-communicative	☐ Contractures

BEHAVIORAL MANAGEMENT: ***Please attach a description of any particular management issues of which the Eleanor Slater Hospital Admission Team should be aware.***

☐ SI ☐ HI ☐ Treatment Non - Compliance ☐ Behavior Plan

☐ Severe Affective Symptoms ☐ Medication Non - Compliance ☐ Unresolved Psychosis

☐ Cognitive Impairment ☐ Restraints Needed ☐ Yes ☐ No ☐ AH ☐VH ☐PI ☐Delusions

☐ Physical Aggression ☐ Yes ☐ No ☐ Verbal Aggression ☐ Yes ☐ No ☐Problematic Sexual Behaviors

☐ Cognitive capacity to make independent decisions ☐ Yes ☐ No ☐ Neurocognitive Testing ☐ Yes ☐ No

☐ Need for single room; specify: _____ ☐ Other_____

INFECTION CONTROL:

☐ MRSA ☐ VRE ☐ ACTIVE TB ☐ ESBL

☐ Special Isolation (Describe): _____

ADLs	Independent	Needs assistance	Unable
Transfers	☐	☐	☐
Ambulation	☐	☐	☐
Ambulation with device	☐	☐	☐
Wheelchair	☐	☐	☐
Bathe self	☐	☐	☐
Dress self	☐	☐	☐
Feed self	☐	☐	☐
Toilet self	☐	☐	☐

CONTINENCE ☐ Continent ☐ Incontinent urine/feces Explain: _____

FOOD & FLUID INTAKE: ☐ Excellent ☐ Fair ☐ Good ☐ Poor

Diet: _____ HEIGHT: _____ **Allergies:** _____

_____ WEIGHT: _____ _____

EQUIPMENT:

Special equipment needed: _____

Air fluidized beds: _____

Other (Describe): _____

LEGAL INVOLVEMENT: Attach copies of all legal documents.

Living Will: ☐ Yes ☐ No Civil Court Certified: ☐ Inpatient ☐ Outpatient

Durable Power of Attorney for Healthcare: ☐ Yes ☐ No History of court involvement: ☐ Yes ☐ No

Petition for Instruction: ☐ Yes ☐ No

Guardian: ☐ Yes ☐ No Contact Name: _____ Contact Number: _____

Explain current or previous court involvement: _____

_____

DOCUMENTATION CHECKLIST: PLEASE ATTACH ALL THAT APPLY. A MINIMUM OF ONE MONTH OF PROGRESS NOTES REQUESTED. ALL DOCUMENTS INCLUDING THE COMPLETED APPLICATION SHOULD BE FAXED TO 401-462-6958.

☐ Physician progress notes ☐ Tests/diagnostics ☐ Medication profile ☐ Nursing progress notes

☐ Initial Psychiatric Assessment ☐ History and Physical ☐ Therapy Notes ☐ Behavior Plan

☐ Neurocognitive Testing ☐ Consultations ☐ MD Narrative of Hospital Course

ELEANOR SLATER HOSPITAL INFORMATION:

Eleanor Slater Hospital (ESH) is a facility that provides Long-Term Care; patients accepted for admission ***must qualify for hospital level of care***. All psychiatric referrals require a primary psychiatric diagnosis and must meet criteria for admission per the ESH Admission, Discharge, and Transfer Policy. The appropriate campus and unit for admission will be determined by the ESH Admission Team. Internal unit transfers between Cranston and Burrillville (Zambarano Campus) are at the discretion of the ESH clinical treatment team at any time following admission. For health and safety reasons, the patient and/or guardian must agree to basic care and personal hygiene throughout the duration of the hospital course. All least restrictive options must be exhausted prior to ESH referral. Documentation of all alternative referrals may be requested when applicable. If / when patients no longer qualify for hospital level services as determined by the current acute care treatment team, discharge to a less restrictive environment becomes mandatory under federal guidelines. Both the patient and family/guardian are to participate and support discharge planning efforts as deemed appropriate by the clinical treatment team. The patient and family/guardian will be notified prior to any such discharge referral.

ALL INFORMATION MUST BE COMPLETE AND ACCURATE. APPLICATIONS WHICH INCLUDE "SEE ATTACHED" WILL BE CONSIDERED INCOMPLETE AND WILL NOT BE REVIEWED UNTIL ALL MATERIALS ARE RECIEVED.

SIGNATURE SECTION:

Applicant's Signature (If unable to sign, guardian or relative) Date

PHYSICIAN VERIFICATION:

Name of Physician (Print) Date of last examination

Contact Phone Number

Physician signature Date