The Canterbury

The art of Creative Living

Name: _____ Phone Number: _____

We are so pleased that you are considering becoming a part of The Canterbury Family! Your application process will begin upon receipt of the following listed items. Upon receipt of these items, a personal meeting with our staff will be scheduled.

_____ **Physician's Report (RCFE)-**To be completed by your physician and returned prior to your meeting with our nursing staff. Please be certain that the TB test results are current (within the last 6 months) Your physician may fax the completed report to the attention of Elizabeth Sax or Patricia Blue at 310-541-9667.
1 per individual.

_____ **Standing Orders/PRN Authorization Forms/Medication List**
To be completed by your physician.
1 per individual.

_____ **Preplacement Appraisal-**This form must be completed prior to your interview with our nursing staff.
1 per individual.

_____ **Resident Financial Data Form-**
1 per individual or couple.

_____ **Identification and Emergency Information-**
1 per individual.

_____ **Referral Disclosure-**
1 per individual/or couple.

_____ **Getting to Know You Form-**
1 per individual.

_____ **DPOA for Financial &Advanced Health Care Directive Recommended-**

_____ **Medical Insurance Cards-**Copies of front and back.

Processing fee of **$750.00** is due following your nursing interview.
Payment of $ _____ Ck#_____.
If you have any questions, please call Elizabeth Sax, Marketing at **310-265-5144** or Patricia Blue, Marketing at **310-265-5134.**

August 2016

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STANDING ORDERS

The following are standing orders requested upon admission. Please draw a line through any orders you do not wish to approve:

RESIDENT NAME:	
Acetaminophen (Tylenol) 325 mg	Two tabs PO every 4 hours PRN for fever over 100.0 degrees, not to exceed 4000 mg from all sources in 24 hours.
Acetaminophen (Tylenol) 325 mg	Two Tabs PO every 4 hours PRN pain , not to exceed 4000 mg from all sources in 24 hours
Loperamide (Immodium AD) 2 mg	Two Tabs by mouth for diarrhea after first loose stool, contact MD if diarrhea is not controlled after 24 hrs.
Loperamide (Immodium AD) 2 mg	1 Tab by mouth for second and subsequent episodes of loose stool, contact MD if diarrhea is not controlled in 24 hours.
Mylanta	30cc's by mouth every 4 hours PRN stomach upset. Notify MD if symptoms persist more than 48 hours
Milk of Magnesia	30 cc's by mouth PRN X1 for constipation
Dulcolax suppository 10 mg	1 suppository rectally PRN X 1 for constipation not relieved 24 hours after Milk of Magnesia. Notify MD if constipation not relieved within 24 hours.
Minor cuts/ abrasions	Cleanse wound with wound cleanser (or soap and water), pat dry. Apply antibiotic ointment. Cover with sterile dressing. Change dressing daily or as needed. Observe wound daily for signs and symptoms of infection: increased redness, swelling, pain drainage or warm to touch , or increased temperature. If resident experiences any of these symptoms, notify MD. Discontinue dressing changes after 2 weeks or when healed.
Minor Skin Tear	Cleanse wound with wound cleanser (or soap and water), pat dry. Cover with sterile dressing, and steri-strips if needed. Change dressing daily or as needed. Allow steri-strips to remain in place until they fall off. Observe wound daily for signs and symptoms of infection: increased redness, swelling, pain drainage or warm to touch , or increased temperature. If resident experiences any of these symptoms, notify MD. Discontinue dressing changes after 2 weeks or when healed.

PHYSICIAN SIGNATURE:		DATE:
PRINT PHYSICIAN NAME:		

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PRN AUTHORIZATION

Community Name: **The Canterbury**

Resident Name: _____ Date: _____

Physician Name: _____

Your patient is resident of our community. To receive PRN medications, including over the counter medications, Community Care Licensing requires that either:

1) Your patient be capable of determining his/her own need for medication, or
2) Your Patient is able to clearly communicate his/her symptoms.

If your patient cannot determine his/her need for a medication, or, clearly communicate the symptoms for a nonprescription medication then you, the physician, must be contacted before the PRN medication can be given.

Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications.

Please Check the Circumstances which best describe your patient:

○ My patient can determine and clearly communicate his/her need for prescription and nonprescription medication on a PRN basis *(Staff will provide assistance with PRN medications as ordered).*

○ My patient cannot determine his/her own need for prescription and nonprescription PRN medication, but can clearly communicate his/her symptoms indicating a need for a nonprescription medication *(Staff will provide assistance with PRN medications as ordered).*

○ My patient cannot determine his/her need for prescription and/or nonprescription PRN medication and cannot communicate his/her symptoms indicating a need for a nonprescription medication (*Staff will contact MD* ***prior to each dose*** *and communicate symptoms. MD must determine whether each dose shall be given).*

Physician Signature: _____ Date: _____

MEDICATION LIST

Name of Resident:____

Date Updated:____

Name of Medication	Dosage	Frequency	Indication

THE CANTERBURY
RESIDENT FINANCIAL DATA FORM

DATE: _____

Applicant Name _____ Phone _____

Address _____

Date of Birth _____ Place of Birth _____

Social Security _____ Health Insurance _____

Co-Applicant Name _____

Date of Birth _____ Place of Birth _____

Social Security _____ Health Insurance _____

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other ☐

Contract Type:
90% Occupancy ☐
60 Mos. ☐

Unit Type _____
Unit No. _____

Entrance Fee $ _____
Monthly Fee $ _____
2nd Person Fee $ _____

Assets - 1st Person		**Assets - 2nd Person**	
Real Estate	$	Real Estate	$
Stock/Mutual Funds	$	Stock/Mutual Funds	$
Life Insurance	$	Life Insurance	$
Savings/CD	$	Savings/CD	$
Bonds/bond funds	$	Bonds/bond funds	$
IRA/Pension	$	IRA/Pension	$
Other Assets	$	Other Assets	$
Total Assets	$	**Total Assets**	$
Monthly Income - 1st Person		**Monthly Income - 2nd Person**	
Social Security	$	Social Security	$
Annuity	$	Annuity	$
Pension	$	Pension	$
Dividends	$	Dividends	$
Interest	$	Interest	$
Other Income	$	Other Income	$
Total Income	$	**Total Income**	$

Monthly Expenses	**1st Person**	**2nd Person**
Prescriptions and other medical costs	$	$
Meals & utilities exclude from monthly resident fee	$	$
Travel and entertainment	$	$
Personal items and clothing	$	$
Automobile expenses	$	$
Other (describe)	$	$
Total Monthly expense	$	$

THE CANTERBURY
RESIDENT FINANCIAL DATA FORM

Liability or debt in excess of $5,000

	1st Person	2nd Person
	$	$
	$	$
	$	$
	$	$

I/WE HEREBY DECLARE THAT ALL STATEMENTS MADE HEREIN ARE TRUE AND COMPLETE ACCORDING TO MY/OURBEST KNOWLEDGE AND BELIEF.

Application to be reviewed prior to residency.
IN WITNESS WHEREOF THE RESIDENT HAS SIGNED THIS ON _____
Date

_____
Applicant

_____
Co-Applicant

_____
Witness

_____
Witness

_____
Approved By

_____
Title

_____
Approved Date

Getting to Know You

Name: _____ Birthdate:_____
Birthplace: City_____, State_____, Country_____
Language spoken_____ First language_____
Preferred name or nickname: _____
Lifetime occupation: _____
Marital status_____ Spouse name_____
Mothers name: _____ Mother's Occupation:_____
Fathers name: _____ Father's Occupation:_____
Brothers/sisters: # _____ Names:_____
Are all siblings living? _____
Children:

Name	Relationship (son or daughter)	Name of their Spouse (or N/A)	Grand Children Names	Great Grand children names

Special memories about children/ grandchildren:
_____
_____
Religious/spiritual background: _____
Devout/ practicing?_____

Favorites:
Movies/ entertainment: _____
Music/ type of music: _____
Artist/ Singer/ Movie Star: _____
Sports: _____
Books: _____
Food: _____
Clothing: _____
Other favorites: _____
Hobbies: _____

Education:
Highest grade attended/ Degree Earned: _____
Name of Grammar school: _____ Jr. High/ Middle School: _____
Name of high school: _____ Favorite Subject: _____
Name/ location of college: _____
Name of best school friend: _____
School days, memories, favorite or humorous events:

Life history
Special skills:

Pets: ___ Yes, I have a pet now. Type: _____ Name: _____
___Yes I have had pets in the past Names of favorite pets: _____
___ No, I have never had pets. ___ Fearful of: (type of pet)_____
___Allergic to (type of pet); _____

First job:

First date w/ spouse:

Wedding day memories:

First home:

Honors/ awards/ proud moments:

Clubs/ community involvement:

Life achievements/ accomplishments:

Travel:

Special memories about family or humorous events:

How do you like to spend the holidays?

Family traditions:

Would your desk/ kitchen shelves be neat or messy?

Do you see the glass as half empty or half full?

What is your attitude toward money?

Are you demonstrative (hugs/kisses):

What would make you really uncomfortable?

Finally, I would like you to know the following about me: