GABLE PINES
AT VADNAIS HEIGHTS

Submitted Application Date: _____ Initials: _____

Residency Type: ____ Independent Living ____ Assisted Living

____ Memory Care ____ Respite

____ Unsure

Date applicant Wishes to Move-In: _____

Preferred Apartment Type (i.e., Two Bedroom): _____

If coming from TCU, SNF, or Hospital

Name of Facility: _____

Social Worker/Discharge Planner Name: _____

Phone Number: _____ Email: _____

Fax Number: _____ Expected Discharge date: _____

Resident information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Current Age: _____

Social Security Number: _____ Gender: MALE ☐ FEMALE ☐ OTHER ☐

Place of Birth: _____ Marital Status: _____ Race: _____

Are you a Veteran? NO ☐ YES ☐ Branch: _____ Dates Served: _____

Eye Color: _____ Hair Color: _____ Identifying Marks: _____

Wears Glasses? NO ☐ YES ☐ Wears Hearing Aids? NO ☐ YES ☐

Do you have an Advanced Health Care Directive, Living Will or POLST? NO ☐ YES ☐

Does applicant have a Power of Attorney, or Guardian? NO ☐ YES ☐

1260 EAST COUNTY ROAD E. • VADNAIS HEIGHTS, MN 55110 • (651) 829-3171 • GABLEPINES.COM

Managed by Life Care Services®

If Yes, Please Attach Appropriate Documentation to this Form.

Resident Assistive Devices:

Does applicant use any devices for mobility? (E.g., Walker) _____

YES or NO? Walks unassisted? _____ Uses a cane? _____ Uses a walker? _____

Uses a wheelchair? _____ If yes, can applicant transfer unassisted? _____

ABILITIES: Please put a Yes or No under the appropriate term

TASK	Independent	Needs some assistance	Total Assist
Grooming			
Bathing			
Dressing			
Escort/Mobility			
Medication Mgt			
Housekeeping			
Toileting			

Emergency Information

In the event of an emergency, we will first contact applicants POA, or designated emergency contact, and secondary contact if the first contact is unable to be reached

- First Contact

First name: _____ Last Name: _____

Relation to Applicant: _____ Phone Number: _____

- Second Contact

First Name: _____ Last Name: _____

1260 EAST COUNTY ROAD E. • VADNAIS HEIGHTS, MN 55110 • (651) 829-3171 • GABLEPINES.COM

Managed by Life Care Services®

GABLE PINES
AT VADNAIS HEIGHTS

Relation to Applicant: _____ Phone Number: _____

Does Applicant have a Preferred Hospital to be sent to? NO ☐ YES ☐

If Yes, Please List: _____

Previous Placements:

- Has applicant ever lived in another assisted living community, or senior living community?

NO ☐ YES ☐ If yes, was the contract terminated by the facility? NO ☐ YES ☐

Please describe reason for leaving:

_____

_____

_____

Care Team

- Please List all Doctors, or Specialists you have seen in the last 12 months

Provider Name	Provider Type	Phone Number	Fax Number	Date Last Seen

1260 EAST COUNTY ROAD E. • VADNAIS HEIGHTS, MN 55110 • (651) 829-3171 • GABLEPINES.COM

Medical History

- Has applicant had any falls in the last 12 months? NO ☐ YES ☐

Date of Fall	Describe Incident/Injury	Did Fall Result in Medical Attention?

- Has Applicant had any Hospitalizations or Post-Acute Care Facility Stays in the past 12 months?

Date(s)	Provider	Reason

1260 EAST COUNTY ROAD E. • VADNAIS HEIGHTS, MN 55110 • (651) 829-3171 • GABLEPINES.COM

- Has Applicant Received any therapies in the Last 12 Months? Including Physical, Occupational, or speech?

Provider Name	Provider Type	Phone Number	Fax Number	Date Last Seen

- Has applicant ever been diagnosed with a cognitive impairment? NO ☐ YES ☐

If Yes, Please Describe Diagnosis: _____

_____

- Has applicant ever been diagnosed with Alzheimer's or Dementia? NO ☐ YES ☐

If Yes, Please Describe Diagnosis: _____

_____

- Has applicant ever been diagnosed with a Mood Disorder? NO ☐ YES ☐

If Yes, Please Check: Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Suicidal Thoughts ☐ Behavioral Disorder ☐

Other ☐: _____

- Does Applicant Experience any Visual or Auditory Hallucinations? NO ☐ YES ☐

If Yes, Please Describe: _____

_____

GABLE PINES
AT VADNAIS HEIGHTS

Authorization for Release of Information

- By completing and signing this form you are authorizing Life Care Services to release the information as completed above. Life Care Services includes LCS, LCS Development, CPS, and Health at Home

I authorize Life Care Services to release the information stated above. I understand I need not to sign this form in order to assure treatment or payment. I understand that upon release, health information is no longer protected by Life Care Services and has the potential to be redisclosed by the recipient. I understand there may be a charge for my records. Revocation: I understand that this authorization will be valid for 12 months from the date signed to release any records created up to the date of signature. Any records created after the date of this authorization will require new authorization. I understand that I may cancel this authorization, by sending a written request for cancellation to Life Care Services, and that the cancellation will take effect when Life Care Services receives my written notice.

Signature	Date
If other than applicant, state relationship and reason applicant unable to sign.	