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RESIDENT REGISTER

The following resident information is to be completed and signed by the Administrator or Supervisor-in-Charge/Administrator-in-Charge and the resident or his/her responsible person within 72 hours of admission and kept in the resident's record in the home. Put "NA" if the requested information is not applicable to the resident.

NAME OF HOME/FACILITY _____

A. **IDENTIFYING INFORMATION**

1. NAME:_____
(first) (middle) (last) (what resident prefers to be called)

2. DATE OF ADMISSION:_____
(month) (day) (year)

3. FORMER ADDRESS_____COUNTY:_____

ADMITTED FROM: ☐ Own Residence ☐ Another's Residence

A facility:_____
(Name) (Address)
Other:_____

4. BIRTHDATE_____ BIRTHPLACE_____ SS#_____

5. MEDICARE #_____MEDICAID #_____OTHER INSURANCE #'S_____

6. MARITAL STATUS: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

7. GENDER: ☐ Female ☐ Male

8. RACE: ☐ Caucasian ☐ African-American ☐ Native-American ☐ Hispanic ☐ Other_____

9. FAMILY: Father_____ Mother_____
(include maiden name)

CHILDREN:_____

SIBLINGS:_____

SPOUSE/PARTNER (Address if applicable)_____

10. RESPONSIBLE PERSON (if applicable)_____

Address_____ Phone ( )_____

Nature of Responsibility: ☐ Guardian ☐ Power of Attorney ☐ Payee

11. CONTACT PERSON (If responsible person is not designated)_____

Phone ( )
Address:_____

B. **RESOURCE INFORMATION**

1. ATTENDING PHYSICIAN:_____

Address_____ Phone ( )_____

2. PREVIOUS PHSYICIAN_____

Address_____ Phone ( )_____

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PLANS MADE FOR PAYMENT OF: Personal Needs_____

Other_____

C. **PERSONAL INFORMATION**

1. ASSISTANCE REQUIRED FOR: (Check all that apply)

☐ Dressing	☐ Correspondence	☐ Mouth Care
☐ Bathing	☐ Getting In/Out of Bed	☐ Feeding
☐ Nail Care	☐ Toileting	☐ Positioning/Turning
☐ Shaving	☐ Hair/Grooming	☐ Scheduling Appointments
☐ Ambulation	☐ Skin Care	☐ Orientation to Time and Place

☐ (other)_____

If different from information contained on the FL-2, home must contact resident's physician for clarification.

2. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

3. SPECIAL AIDS: (Check all that apply)

☐ Walker	☐ Hearing Aid	☐ Wheelchair
☐ Eyeglasses	☐ Dentures (Type)_____	☐ Other_____

4. PERSONAL HABITS: ☐ Smoking ☐ Alcohol ☐ Other_____

5. **KNOWN ALLERGIES OR SUBSTANCES NOT TO BE ADMINISTERED (Drug, Food, or Otherwise):**

6. FOOD PREFERENCES: If special diet, please describe:_____

_____

	FAVORITE	LEAST FAVORITE
Vegetable		
Fruit		
Meats		
Meat Substitutes		
Cereals and Breads		
Milk or Buttermilk		
Other Beverages		

7. COMMUNITY INVOLVEMENT

a. FAITH COMMUNITY_____ PASTOR_____

Address_____ Phone ( ) _____

b. CLUB, GROUP OR ORGANIZATIONAL MEMBERSHIPS_____

c. SPECIAL SKILLS OR TALENTS_____

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d. PAST WORK AND VOLUNTEER SERVICE_____

e. HOBBIES_____

f. ACTIVITY INTERESTS: (Review *Listing of Suggested Activities with resident*).

	Favorite
Games	
Music	
Exercises	
Outdoor Activity	
Crafts	
Outings	
Social Activity	
Work Type/Volunteer Activity	
Intellectual Activity	

g. ACTIVITIES STRONGLY DISLIKED OR TO BE AVOIDED:_____

If there is a question about a resident's ability to participate in an activity, the home must obtain a statement from the resident's physician regarding the resident's capabilities.

D. **REQUEST FOR ASSISTANCE**

Below are some areas in which the home can assist a resident upon the request of the resident or his/her responsible person. The administrator or supervisor-in-charge/administrator-in-charge must explain and complete each statement with the resident or his/her responsible person. The resident or his/her responsible person may subsequently change his/her mind and make a new request in writing at any time using Section H or some other notice. An equivalent signed record can be substituted for Section D.

1. I, as resident or the resident's responsible person, request that pertinent information be secured from the facility from which I just left. Signature:_____

2. I, as resident or the resident's Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the right to examine my account or to withdraw this request at any time. Signature:_____

3. I, as resident or the resident's responsible person, request the use of lockable space for the security of personal valuables. I understand that I am entitled to one key at no charge and this space is accessible only to me, the administrator or supervisor-in-charge. Signature:_____

4. I, as resident or the resident's responsible person, request that the management of this home –
   a. Open my personal mail in my presence to read and explain the contents to me;
   b. and assist in handling my mail that pertains to my financial or medical affairs.
   Signature:_____

E. **RECEIPT OF MATERIALS**

I, as resident or the resident's responsible person, acknowledge receipt of the following information which the management of the home reviewed with me:

Home's resident contract specifying rates for the resident services and accommodations

House Rules which include policies on refunds, smoking, alcohol consumption visitation, and reasons for discharge.

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Declaration of Residents' Rights.

Home's grievance procedures for residents to present complaints and make suggestions as to the home's policies and services.

Home's willingness to comply with Title VI of Civil Rights Act.

Other:_____

_____

Signature_____

F. **SIGNATURES**

The resident or his/her responsible person should be asked to sign this form only after Sections A-E have been completed. The administrator or supervisor-in-charge/administrator-in-charge is to review this form with the resident or his/her responsible person at least once a year and revise it as needed using Section H. Section G is to be completed at the time the resident is discharged or transfers from the facility.

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

G. **DISCHARGE/TRANSFER INFORMATION**

1. NOTICE OF DISCHARGE/TRANSFER_____
(Month) (Day) (Year)

2. INITIATED BY: ☐ Administrator ☐ Other_____
Reason(s)_____

3. DATE OF DISCHARGE/TRANSFER_____
(Month) (Day) (Year)
To: ☐ Own Residence ☐ Another's Residence (Name)_____
☐ A Facility ☐ Other_____

4. New Address_____ Phone ( )_____

I acknowledge the above information to be complete and accurate.

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

H. **REVIEW/REVISION**
The space below may be used to revise the information contained on the form.

Changes:_____

_____

_____
(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator –in-Charge) (Date)

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