EMERGENCY ROOM/HOSPITAL ADMITTANCE FORM

Form to be completed by residential staff prior to bringing the individual with mental retardation to the Emergency Room or admitting the individual to the hospital.

Date: 01/23/24 Completed by: _____ Relationship to Individual: _____

Name: Starla Cristofaro Nickname/Likes to be called: _____

DOB: 09/30/83 Soc Sec #: 9872528

Address: 72778 Pine View Way

Phone #: 948-996-6330

Health Insurance (Type & Numbers)

Primary: _____

Secondary: _____

Allergies: latex

Living Status: Group Home____ Family Living____ Lives Independently ✓ Other_____

Nursing Supports Available at provider agency? (circle) Yes or No; RN and/or LPN Name: _____

Emergency Contacts

Name (Provider Agency): Goodwin-Ortiz
Phone Number: 651-686-8500
Phone Number (After Hours): _____

Name (Family): Niccolo Dalgarnocht
Relationship: father
Phone Number: 222-845-6739

County Contact Person: _____
Phone Number: _____
Phone Number (After Hours): _____

Primary Care Physician: _____
Phone Number: _____

Neurologist: _____
Phone Number: _____

Psychiatrist: _____
Phone Number: _____

Reason for ER visit today:

Animal bite

Current Medical Problems/Diagnoses:

Level of Mental Retardation (circle one):
Mild Moderate Severe Profound

Consent Status:

- ☑ CAN give own consent
- ☐ CANNOT give own consent. Has a Legal Guardian.
  Legal Guardian: _____ Phone Number: _____
- ☐ CANNOT give own consent. Does not have a Legal Guardian. Has a Substitute Healthcare Decision Maker.
  Name: _____ Phone Number: _____
  Medical Durable POA: _____ Phone Number: _____

Resuscitation Status:

- ☐ DNR****
- ☑ Full Resuscitation

If DNR, List Reason: _____ Date DNR Given: _____ By Whom: _____

Consent for Release of Information to Provider(circle one): Yes No

Date of Last Tetanus: _____ Date of Last PPD: _____ Date of Last Flue Shot: _____
Date of Last Pneumovax: _____ Date of Hepatitis B Vaccines: _____

[illegible]