1169 Spring Lake Road
Cuttingsville, VT 05738
802.492.3322
www.springlakeranch.org

Rutland Program
26 Washington Street, Box 9
Rutland, VT 05701
802.775.0808

APPLICATION FOR ADMISSION

Today's Date ____________ Person Filling out Application __________________________
Applicant's Name ____
Address ________________________________ City _________________ State/Zip ____________
Phone _______________________ Cell ________________________ Other _______________
SSN ______________________ email: ____
Date of Birth __ /__ /____Male ____ Female ____ Marital Status: _______________________

1) Family (please list both mother and father)

MOTHER

Name ____
Address _________________________________City___________________ State/Zip ________
Phone _____________________ Cell _______________________ Work _______________
Email ____ Occupation ________________________
Marital Status: Married Divorced Widowed Single

FATHER

Name ____
Address _________________________________City___________________ State/Zip ________
Phone _____________________ Cell _______________________ Work _______________
Email ____ Occupation ________________________
Marital Status: Married Divorced Widowed Single

Is there a court appointed legal Guardian or Power of Attorney for Medical or Financial purposes?
Y ____ N ____.
If so, please fill in information below, and bring a copy of documentation for our records.
Name __________________________ Phone _______________ Email _____________________
Address___________________________________ City_________________ State/Zip ________

It is important that we receive page 1-4 of this form and psychiatric records prior to your visit.
Please mail or fax this completed form to 802.492.3331 (Attention: Admissions)

Emergency Contacts

1. Name ______________________________ Relationship ____________________________

Phone ____________ Cell _____________ Work _____________ Email ___________________________

2. Name ______________________________ Relationship ____________________________

Phone ____________ Cell _____________ Work _____________ Email ___________________________

2) Referral Source – Where did you hear about Spring Lake Ranch?

Name ____________________________________ Hospital ____________________________________

Address _____________________________________ City________________ State/Zip____________

Phone _________________________ Email ____

3) Person financially responsible for resident ____

4) Health Insurance Co. ______________________________________ Phone _____________________

Address _______________________________________ City ___________________ State/Zip ________

Policy # __________________________________ Group # _______________________________________

Policy Holder ______________________________ Policy Holder's Date of Birth ____/_____/_____

Medicare _________________________________ Medicaid _________________________________

5) Medical Requirement: If the applicant has had a physical examination within the past 90 days, we will require a copy of that record. If not, it is a state licensing requirement that we schedule an appointment for a physical within 45 days of admission. The attached general medical information sheet must also be completed prior to arrival.

6) Are there any current or pending legal issues or probation requirements? If yes, please explain.

____

____

____

7) **Identification**. Upon admission, please provide copies of the following documentation and identification so that we will have a copy on file: 1) Insurance Cards 2) Valid Driver's License or Photo ID or Passport.

FOR SLR USE ONLY

Admission Date___________________ Previous Stay_____________________________

House_____________________________ HA______________________________________

LT____

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General Medical Information

Name of Applicant: ______________________________ Date of Birth: ____________________________

Person filling out this form: ______________________________ Date: ___________________________

Personal Medical History:

Please indicate whether resident has had any of the following medical problems, and approximate dates

________ High cholesterol ________ High Blood Pressure ________ Kidney disease
________ Diabetes ________ Thyroid problem ________ Seizure
________ Asthma/Lung Disease ________ Head Injury ________ Lyme's disease
________ Heart Disease (specify)__________________ ________ Cancer(specify) ____________
Major Surgeries _______________________________________ ________ Other(specify) _____________

Allergies or reactions to medications: ____

What medical aids or devices such as glasses, CPAP, prosthesis, are you currently using?
____

Date of your most recent IMMUNIZATIONS:

Hep A _______ Hep B _______ Influenza (flu Shot)_______ MMR _______ Pneumovax (pneumonia)_______ Tetanus ______

Meningitis _______ Varicella shot _______ Chicken Pox illness _______ Tdap (tetanus & pertussis) _______

Tobacco Use

Cigarettes: ☐ Never ☐ Quit Date___________ ☐ Current Smoker: Packs/day ________ #of yrs __________

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Chew Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes (Number of drinks per week) ________

Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs? ☐ Yes ☐ No

Have you ever used needles to inject drugs? ☐ Yes ☐ No

Other information that may be helpful in your care and treatment:

____

____

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Please list all medications (psychiatric and medical) you are currently prescribed and any non-prescription medicines, vitamins, remedies, birth control pills, or herbs you take on the next page:

List all Current Medications:

Medication	Dose	Times per day

Medication	Dose	Times per day

List any non-prescription medicines, vitamins, remedies, birth control pills, or herbs you take:

Medication	Dose	Times per day

Medication	Dose	Times per day

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