



1169 Spring Lake Rd.
Cuttingsville, VT 05738
Phone 802-492-3322 fax 802-492-3331

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 _____

Emergency Contact: #1 Name _____ Relationship _____

Phone _____ Cell _____ Work _____ email: _____

#2 Name _____ Relationship _____

Phone _____ Cell _____ Work _____ email: _____

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

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 Drivers License or Photo ID or Passport.

For SLR use only:

Admission Date _____ Previous Stay _____

House _____ HA _____

LT _____

General Medical Information

Name of Applicant: _____ Date of Birth: _____

Person filling out this form: _____ Date: _____

Personal Medical History:

Please indicate whether you have 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: _____

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:

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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