



Thank you for your interest in West View Health Care Center. Whether you are looking for a short term visit or permanent placement, it is our mission to provide the best possible care by partnering with our residents so they can achieve their maximum level of independence. Please complete the enclosed application to the best of your ability and return to the address below. We also encourage you to visit our website for more information about West View and to view our virtual tour. I would like you to know that we are family owned for over 30 years. While we are proud of our “family approach”, you should be comforted to know that our highly trained staff can provide the most complex care that your family member may require. Feel free to contact our Admissions Department to schedule a tour and review your application. Thanks again for your interest and we look forward to the opportunity to care for your loved one.

Sincerely,

Hugh Hall, Administrator
West View Health Care Center
239 Legris Avenue
West Warwick, RI 02893
(401)828-9000
www.westviewnursing.com

Please email or fax this form back to West View Health Care Center.
Email : Jennifer@westviewnursing.com
Fax #: 401-615-5962



ADMISSION APPLICATION

Date: _____

Resident Name and Address: _____

Date of Birth: _____ **Age:** _____ **Religion:** _____

Marital Status: S M D W

Primary Insurance: Medicare _____ Blue Chip _____ United Health _____ Medicaid _____

Backup Insurance Plan: Blue Cross _____ United Health _____ Medicaid _____ Other _____

***Please refer to Medicaid handout to see eligibility guidelines. If you believe this resident may be eligible, please call the Department of Human Services at 462-4000 to request an application. If you are already applying or have been approved for Medicaid, please indicate so above. If Medicaid is not checked off above, then it will be assumed that the resident would qualify as private pay.

Primary Physician: _____

Diagnosis: _____

Allergies: _____ **Infections:** _____

Reason for Placement (circle one): Short term Rehab Respite Long term permanent placement Hospice

Current Functional Status (circle all that apply):

Personal care: complete assistance partial assistance supervision only independent

Continence (bladder): continent incontinent
(bowel): continent incontinent

Nutrition: feeds self needs assistance Diet: _____

Ambulation: walks independently uses walker uses cane uses wheelchair pivots only Hoyer lift poor balance

Please list any other special equipment resident may use i.e.: oxygen, raised toilet seat, electric recliner chair, ect. _____

Height: _____ **Weight:** _____

Skin Condition/Treatments (please indicate any open areas): _____ (over)



(cont.)
Mental Status: Alert Oriented Agitated Anxious Depressed Paranoid Forgetful Confused Combative
If confused or diagnosed with Alzheimer's, does resident wander? Yes No

Current Medications:

Previous hospitalizations and or nursing home stays (please include where, dates, and reason):

Does the resident smoke? Yes No **PLEASE NOTE: WEST VIEW HEALTH CARE CENTER IS A NON-SMOKING FACILITY AND, AS SUCH, DOES NOT ADMIT SMOKERS.**

Please describe resident's current living situation. List any/all persons or agencies involved in their care.

Name of person completing this form: _____
Address and phone number(s): _____

Relationship to resident: _____

How did you hear about West View Health Care Center?
Advertisement Internet Referred by hospital Referred by other: _____
Other: _____

THANK YOU! YOU WILL HEAR FROM US SHORTLY!



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