Our Lady of Peace
HOSPICE & HOME HEALTH CARE

OUR LADY OF PEACE RESIDENTIAL HOSPICE

2076 St. Anthony Avenue., St. Paul, MN 55104
Main Phone 651-789-5031 / Fax 651-646-7884
www.ourladyofpeacemn.org

To: Our Lady of Peace Admission – Fax: 651-646-7884

From – Name/Company: ______________

From - Phone Contact: ______________

Date/Time: ________________________

NECESSARY DOCUMENTATION TO REVIEW FOR ADMISSION

- ❑ ***Completed application (Admissions Form)***
- ❑ ***FACE Sheet including payer information***
- ❑ ***DNR/DNI/To allow for natural death***
- ❑ ***Application with approval to admit by Physician or Nurse Practitioner***
- ❑ ***Most recent medication list (MAR)***
    - ❑ ***Include Opioid totals in last 24 hours if applicable***
- ❑ ***History & Physical from a hospital or clinic and progress notes listing comorbidities and evidence of terminal disease***
- ❑ ***Information including:***
    - ❑ ***Reports from CT/MRI/PET***
    - ❑ ***Functional Status***
- ❑ ***Copy of Advance Healthcare Directive – or Health Care Power of Attorney***

If you have any questions, please contact:

Patrice Engelmann @ patricee@ourladyofpeacemn.org
651-789-5023 – phone
651-646-7884 - fax

Our Lady of Peace Home is a licensed nursing facility for terminally ill patients. All curative treatments must be completed prior to admission. OLP Residential Hospice is Medicare Certified & is also supported by the donations of a generous public. This facility does not discriminate because of race, color, creed, religion, sex, age, physical or mental disability, national origin, marital status or sexual orientation.

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NAME____DATE__________________
First Middle Last (Maiden)

ADDRESS____
Street City County State Zip

BIRTHDATE_______________AGE__________RACE____________RELIGION______________________

BIRTHPLACE____PHONE #_________________________
City State

MEDICARE/INSURANCE NUMBER____________________MEDICAID NUMBER_______________________

MARITAL STATUS_____________________NAME OF SPOUSE__________________________________

OCCUPATION________________________________SOCIAL SECURITY# _______/_______/__________

TERMINAL DIAGNOSIS____

PRIMARY SITE (IF CANCER)__________________________________DATE OF ONSET_______________

PROGNOSIS IN DAYS/WEEKS____

BRIEF HISTORY____

____

____

____

____

CO-MORBIDITIES/SECONDARY DIAGNOSES____

CONTAGIOUS OR COMMUNICABLE DISEASE____

ALLERGIES____

PATIENT'S CURRENT LOCATION____

COMMUNICATION: ABLE TO SPEAK______SPEAKS ENGLISH_______OTHER_________NEEDS INTERPRETER______

ACTIVITY LEVEL: COMPLETE BED PATIENT___________AMBULATORY_________CHAIR__________

SMOKER STATUS: CURRENT________________FORMER______________________NON SMOKER________________

HISTORY OF MENTAL ILLNESS____

HISTORY OF VIOLENT BEHAVIOR____

DELIRIOUS__________SUSPICIOUS___________BELLIGERENT________ALCOHOLIC/CHEMICALLY DEPENDENT___________

DIET: REGULAR__________________SPECIAL______________TUBE FEEDING/TYPE_________________________________

ELIMINATION: CONTINENT_________INCONTINENT___________FOLEY CATHETER_________COLOSTOMY_______________

UROSTOMY___________ OTHER _____________ PATIENT'S APPROXIMATE WEIGHT ______________HEIGHT ____________

LEVEL OF CONSCIOUSNESS: ALERT_______________LETHARGIC________________UNRESPONSIVE____________________

CURRENT MOOD/BEHAVIOR: DEPRESSED___________CONFUSED__________NOISY___________QUIET_________________

OTHER COMMENTS____

SUPPLIES/EQUIPMENT: OXYGEN_________SUCTION MACHINE____________PLEURX DRAIN_________________________

SPECIAL MATTRESS____________TRACH TUBE____________CPAP____________OTHER______________________________

CODE STATUS/POLST/ADVANCED DIRECTIVE____

NAME OF HOSPICE IF APPLICABLE_____________________________________START DATE___________________________

______OKAY TO ADMIT TO OUR LADY OF PEACE HOSPICE

PHYSICIAN____SIGNATURE____

PRIMARY DOCTOR/ONCOLOGIST____

ADDRESS ____PHONE NUMBER___________________________

RESPONSIBLE PARTY/HEALTHCARE AGENT____________________RELATIONSHIP______________________________

ADDRESS____CELL OR PRIMARY PHONE____________________

SECOND PERSON____RELATIONSHIP_________________________

ADDRESS____ CELL OR PRIMARY PHONE ___________________

SOCIAL WORKER____PHONE______________________________

EMAIL____

DOCUMENTATION REQUIREMENTS: DO NOT RESUSCITATE (DNR)/DO NOT INTUBATE (DNI)/ALLOW NATURAL DEATH. APPLICATION SIGNED BY PHYSICIAN OR NURSE PRACTITIONER. MOST RECENT MEDICATION LIST. RECENT HISTORY AND PHYSICAL FROM A HOSPITAL OR CLINIC. PROGRESS NOTE WITH PAST MEDICAL HISTORY, COMORBIDITIES AND EVIDENCE OF TERMINAL DISEASE. RECENT CT/MRI/PET SCANS, COPY OF ADVANCE DIRECTIVE IF PRESENT.

ADMISSION CONTACT INFORMATION: Patrice Engelmann at patricee@ourladyofpeacemn.org 651-789-5023