



## REGINA NURSING CENTER

550 East Fornance Street  
Norristown, Pennsylvania 19401-3561  
(610) 272-5600

*Thank you for your interest in the Regina Nursing Center.*

*Enclosed please find general information that may answer some questions that you have. Should you have any further questions or would like to set an appointment to see the Facility please feel free to contact Michele Michaels or Keith Schaefer.*

*Also, enclosed are an Admission Inquiry form and a History and Physical document that must be completed and returned in order to be placed on the waiting list. Inquiries that are received are kept on file for six (6) months unless we have been advised otherwise.*

*Again, thank you for your interest in the Regina Nursing Center.*



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Please be advised, that effective 3/1/06, all potential admissions being considered for long term care at Regina Nursing Center must have a copy of Options Assessment from the Office of Aging and Adult Services. Please forward this assessment along with the Admission Inquiry and History and Physical from your Physician to Regina Nursing Center as quickly as possible. Once these 3 items have been received, we will be happy to review your loved one's information and contact you with our bed availability.

If you have not had an Options Assessment done on your loved one, you may contact Aging and Adult Services at 610-278-3601. Ask for the Intake Department and let them know you need an Options Assessment for Long Term Care Nursing in a Nursing Facility.

If you have any questions, please feel free to contact our Admissions Department at 610-272-5600.



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### GENERAL INFORMATION FOR ADMISSION

1. If the guest is ambulatory, he/she will need several changes of comfortable clothing, and in addition to pajamas or gowns, a washable robe and slippers. **ALL CLOTHING MUST BE LABELED WITH THE RESIDENT'S NAME.** Our facility prefers you put the resident's name onto the clothing with a permanent marker. We will provide and attach name labels to the clothing that we are responsible for washing. Any article of clothing brought in during the guest's stay should be similarly labeled and recorded on the guest's clothing list at the nurses' station.
2. When visitors bring food for a guest, it is important to first receive approval from the charge nurse. The wrong food may prove harmful to our guests because of diet restrictions. **ALL FOOD MUST BE KEPT IN AIRTIGHT CONTAINERS AND NOT LEFT UNCOVERED IN THE ROOMS.**
3. Suggested visiting hours are from 10 a.m. to 8 p.m. daily. If activity programs are in progress, visitors are most welcome and encouraged to attend. Mass is celebrated weekly in our living room. **ONCE MASS HAS BEGUN, WE DO NOT PERMIT RESIDENTS TO BE TAKEN OUT BY VISITORS.** In semi-private rooms, please respect the other occupant so that each roommate can have a maximum of privacy and rest. Whenever there are epidemics of the flu or other infectious conditions, we strongly urge that children not visit because our residents are highly susceptible to infection.
4. Each floor has a public phone that is easily accessible for use by our residents. We recommend the use of these phones for personal calls. The number of the pay phone on the second floor is (610) 272-8131. The number on the third floor is (610) 272-8135. There is also a phone in the nursing office on the second and third floors, which can be used by residents to ensure privacy for calls. A resident is permitted to have a private phone at his/her expense.
5. The cost for personal laundry is \$25.00 per month. The family, however, has the option of taking personal laundry home. In either event, clothing must be properly marked so as to be easily identified.
6. Meals are served to visitors of our guests provided our dietary staff is notified 24 hours prior to the time you plan to eat with your family member.

7. Release of Responsibility forms are available at each nursing station and must be signed by the person taking a guest from our facility for visiting, recreation, or any other reason. When such an outing is planned, please be sure to advise the nursing office or the front desk so resident is ready at the time the visit is planned and medication schedule is prepared in the event resident is away from the facility for an extended period.
8. We cannot be responsible for valuables such as jewelry or money in excess of \$1.00. We recommend that residents leave all money in the business office for safekeeping and we require signed permission for this service. It is not necessary for our residents to have an excess amount of funds since services such as barber, beauty shop, name tags, etc. are billed to the responsible party.
9. Bills for room, board, and nursing care are payable in advance. You will receive a bill at the beginning of each month for the months care, and payment is required within 10 days after receipt of the statement.
10. Any resident who becomes hospitalized or goes on leave of absence and wants to have his/her bed held until his/her return, there will be a daily charge of ten dollars less the current room rate.  
  
\*If a patient who participates in the Medical Assistance program is hospitalized, we will hold the bed for a maximum of 15 days per hospitalization.
11. Not included in the basic fee are medications and supplies, laboratory studies, X-rays, physician and podiatrist or dental services, personal laundry, and personal care. Any nursing service not provided by Regina is available at residents' expense.
12. Before discharge, we require a 3-day notice be given our administrative offices.
13. The attending physician of record must order any referrals to a health care provider. This includes medical/surgical specialists, eye doctors, dentist, and podiatrists. Please advise the head nurse on the residents' floor in advance of any appointments. The attending physician must countersign all orders for prescription or treatments.
14. It is the policy of the Regina Nursing Center to admit and to treat all residents without regard to race, color, national origin, or religious creed. There is no distinction in eligibility for, or in the manner of providing any resident service provided by or through the nursing home, in compliance with title VI as required by the state regulations.



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### ADMISSION INQUIRY

#### 1. RESIDENT DEMOGRAPHIC DATA:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

SOCIAL SECURITY  
NUMBER \_\_\_\_\_

OTHER INSURANCE COMPANY  
POLICY # \_\_\_\_\_

MEDICARE NUMBER  
PRESCRIPTION COVERAGE (NAME & POLICY #)  
\_\_\_\_\_

#### PLEASE ATTACH COPIES OF ALL INSURANCE INFORMATION AND CARDS.

MARITAL STATUS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

RELIGION \_\_\_\_\_

PLACE OF BIRTH  
(CITY, STATE, COUNTRY) \_\_\_\_\_

EDUCATION (LAST GRADE COMPLETED) \_\_\_\_\_

CURRENT LIVING SITUATION \_\_\_\_\_

NUMBER OF CHILDREN \_\_\_\_\_

SPOUSE NAME (EVEN IF DECEASED) \_\_\_\_\_

MILITARY SERVICE (INCLUDE BRANCH) \_\_\_\_\_

REFERRED FROM: \_\_\_\_\_

OCCUPATION (CANNOT PUT "RETIRED") \_\_\_\_\_

LANGUAGE SPOKEN \_\_\_\_\_

ETHNIC BACKGROUND \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

#### 2. WHAT PRECIPITATES NURSING FACILITY PLACEMENT?

PLEASE INCLUDE SIGNIFICANT PAST MEDICAL HISTORY

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3. DOES POTENTIAL RESIDENT HAVE ANY OF THE FOLLOWING  
ADVANCED DIRECTIVES \_\_\_\_\_ POWER OF ATTORNEY (IF SO REGISTERED TO VOTE  
WHOM) \_\_\_\_\_

PREPAID FUNERAL/IRREVOCABLE BURIAL

(IF SO WITH WHOM) \_\_\_\_\_

PLEASE ATTACH: COPIES OF LIVING WILL OR ADVANCED  
DIRECTIVE, AND POWER OF ATTORNEY

4. FAMILY CONTACT PERSONS: PLEASE INCLUDE FULL NAME, ADDRESS, AND  
PHONE NUMBERS, AS WELL AS RELATIONSHIP TO POTENTIAL RESIDENT

1st Contact  
NAME

2nd Contact  
NAME

RELATIONSHIP

RELATIONSHIP

ADDRESS

ADDRESS

E-MAIL

TELEPHONE HOME

TELEPHONE HOME

WORK

WORK

CELL

CELL

3rd Contact  
NAME

4th Contact  
NAME

RELATIONSHIP

RELATIONSHIP

ADDRESS

ADDRESS

TELEPHONE HOME

TELEPHONE HOME

WORK

WORK

CELL

CELL

5. FINANCIAL INFORMATION:

A. MONTHLY INCOME AND SOURCE \_\_\_\_\_

B. IF PENSION, SOURCE OF PENSION \_\_\_\_\_

C. DOES POTENTIAL RESIDENT OWN HOME? \_\_\_\_\_  
ADDRESS OF HOME \_\_\_\_\_

D: HAS POTENTIAL RESIDENT SET UP ANY TRUST FUND(S) FOR ANY ASSETS INCLUDING HOME \_\_\_\_\_  
INCLUDE COPY OF TRUST AGREEMENT WITH THIS INQUIRY

E: HAS POTENTIAL RESIDENT GIFTED/TRANSFERRED ANY ASSETS/RESOURCES IN THE PAST FIVE YEARS? PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

F. VALUE OF THE FOLLOWING:

SAVINGS

CHECKING

STOCKS

BONDS

LIFE INSURANCE

MUTUAL FUNDS

CD/ANNUITY

TRUST FUND

6. OTHER INFORMATION:

A. HAS POTENTIAL RESIDENT BEEN IN ANOTHER FACILITY, IF SO WHERE AND WHEN?  
\_\_\_\_\_  
\_\_\_\_\_

B. HAS POTENTIAL RESIDENT HAD OUTPATIENT THERAPY WITHIN THE PAST YEAR? IF SO WHERE AND WHEN?  
\_\_\_\_\_  
\_\_\_\_\_

C. HAS POTENTIAL RESIDENT BEEN HOSPITALIZED IN THE LAST TWO YEARS FOR PSYCHIATRIC TREATMENT?  
\_\_\_\_\_  
\_\_\_\_\_

DATE \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PERSON COMPLETING THIS FORM  
(SIGNATURE IS ALSO A RELEASE OF INFORMATION FOR THE PURPOSE OF ADMISSION TO REGINA NURSING CENTER)

**\*NOTE: PLEASE ATTACH COPIES OF LATEST 3 BANK STATEMENTS FOR ALL ACCOUNTS HELD BY APPLICANT.**



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## ADMISSION MEDICAL ASSESSMENT FORM TO BE COMPLETED BY PHYSICIAN

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

PRESENT ILLNESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

VITAL SIGNS \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

PAST MEDICAL HISTORY \_\_\_\_\_

\_\_\_\_\_

PAST SURGICAL HISTORY \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### CURRENT MEDICATIONS (INCLUDE DOSE AND FREQUENCY):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_

10. \_\_\_\_\_ 11. \_\_\_\_\_ 12. \_\_\_\_\_



# REVIEW OF SYSTEMS

A. General

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B. Skin

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C. HEENT/Neck

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D. Respiratory

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E. Cardiovascular

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F. Gastrointestinal

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G. Genitourinary

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H. Musculoskeletal

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I. Neuro- Psychiatric

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J. OB/GYN

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K. Additional Information that may be relevant

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Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_



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### RELEASE OF MEDICAL INFORMATION

Please release to Regina Nursing Center the medical information you have in your file on \_\_\_\_\_ while a patient at your facility.

Please send this information marked to my attention.

Please be advised that I give permission for an employee of Regina Nursing Center to visit your facility and have access to the medical records and to assess the person for whom I am the responsible party.

Thank you,

\_\_\_\_\_  
Michele Michaels, LPN  
Director of Admissions

I hereby give permission for the release of my medical information to Regina Nursing Center.

\_\_\_\_\_  
Resident Name

\_\_\_\_\_  
Responsible Party Signature



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The Regina Community Nursing Center was founded in 1963 for the purpose of providing nursing care to the mentally and physically handicapped, the chronically ill, and the aged.

Regina Nursing Center is a 121 bed fully operational skilled nursing facility with trained staff including registered nurses, certified nursing assistants, and orderlies. The current daily room rate is \$310.00/day for a semi-private room, \$340.00/day for a private room, \$490.00/day for special care, and \$455/day for a Medicare A Private Pay room. There is a monthly laundry charge of \$25.00 additional. Personal Care, such as hairdresser and barber, is also available for the residents' convenience.

Attending physicians affiliated with surrounding area hospitals, podiatrists, and dentists are also available.

Regina Nursing Center is staffed with certified Recreational Therapists and their aides, who provide the required mental and physical stimulation, which is so vital to the health of each resident. Physical and Occupational Therapies are also available subsequent to an admission evaluation by registered therapists and a physician's order.

The admissions Personnel are available Monday through Friday, 8:00 a.m. to 4:00 p.m. to answer any questions you may have.

04/2018