Terrace Lake
ASSISTED LIVING

Pre-Admission/ Waiting List

Please fill out and mail to:
Terrace Lake Assisted Living
100 Terrace Lake Drive
Guntersville, AL 35976
Attn: Michele Watson

Patient/Resident Contact Information:			
Name			
Street	City	State	Zip
Phone ( )	Email		
Current Location: ❑ Home ❑ Family Member's Home ❑ Another Assisted Living Facility ❑ Other, please explain:		Current Contact Information: Phone: ( )	
Age	Primary Care Physician		
Sponsor/Family Member Contact Information:			
Name			
Street	City	State	Zip
Phone ( )	Email		

Dressing (select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance	Basic Grooming (select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance	Feeding him/herself (select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance	Walking/Mobility (select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance
Select one: ❑ Walker ❑ Wheelchair ❑ Both ❑ Neither	Toilet him/herself (select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance	Transfer from bed to chair (select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance	Bathe him/herself(select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance
Turn him/herself (select one): ❑ No Assistance ❑ Minimum Assistance ❑ Maximum Assistance ❑ Total Assistance	Has he/she ever wandered? ❑ Yes ❑ No IF YES, have they wandered outside of the home? ❑ Yes ❑ No	Does he/she have difficulty sleeping? ❑ Yes ❑ No ❑ Sometimes	Does he/she have a history of falls? ❑ Yes ❑ No ❑ Sometimes
Has he/she ever had any fractures? ❑ Yes ❑ No	Can he/she follow verbal directions? ❑ Yes ❑ No ❑ Sometimes	Has he/she had recent weight loss? ❑ Yes ❑ No IF YES, Amount lost _____ Previous weight _____	Has he/she ever smoked? ❑ Yes ❑ No

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Has he/she currently smoke? ❑ Yes ❑ No	Has he/she ever had the pneumonia vaccine? ❑ Yes ❑ No IF YES, when? _____	Has he / she had a current flu vaccine? ❑ Yes ❑ No

Has he / she received therapy this year?
❑ Yes ❑ No

IF YES, where?

_____

Has he/she been in rehab, another assisted living facility, or another nursing home in the past year?
❑ Yes
❑ No

IF YES, where?

_____

Has he / she received Hospice services this year?
❑ Yes
❑ No

If so, which hospice company / provider?

_____