

# Admission Checklist / Fax Cover Sheet

Facility Name: \_\_\_\_\_ Name of Staff Completing Admission: \_\_\_\_\_

Resident Name: \_\_\_\_\_ Unit/Room Number: \_\_\_\_\_

**Select One of the Following Options**

New Admission  Re-Admission

Admission Date:

**All Information is REQUIRED for admission to be accepted by the pharmacy.**

Send information to 207-373-9088 or [ecm.maine@guardianpharmacy.net](mailto:ecm.maine@guardianpharmacy.net)



### Select Level of Care

- SKILLED-PRIMARY PAYOR: \_\_\_\_\_
- LONG TERM CARE  ASSISTED LIVING  GROUP HOME  OTHER



### Patient Demographics

- NAME  PRIMARY PROVIDER  DOB  DRUG ALLERGIES  SSN



### Contact Information of Financial Responsible Party (MUST BE CURRENT)

- MAILING ADDRESS  PHONE NUMBER  EMAIL ADDRESS



### Insurance Information

- MEDICARE #  PRESCRIPTION INSURANCE INFO  RX BIN  PCN #  RX GROUP



### Patient Medications

- SIGNED ORDERS  DISCHARGE SUMMARY  IV or Compound Medications

#### How are electronic prescriptions being sent to Pharmacy?

- PROVIDER OFFICE  HOSPITAL  ADMITTING COMMUNITY PROVIDER

#### What medications need to be ordered?

- Send all medications listed  Send all, but house stock  Send NO medications

List Patient Medications (You must indicate above what action the Pharmacy should take with medications listed.)

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