Facility Name: _____

Name of Facility Staff Completing Admission: _____

Admission Checklist/Fax Cover Sheet

☐ **New Admission**
☐ **Re-Admission**

Please complete and send with admission packet

Patient Demographics

- ☐ Name
- ☐ DOB
- ☐ SSN
- ☐ Medicare Number
- ☐ Primary Physician
- ☐ Drug Allergies

- ☐ Financial/Medical POA contact information *(if different from patient)*
- ☐ Mailing Address
- ☐ Phone Number

- ☐ Insurance information
  - ID #
  - RX BIN #
  - PCN #
  - RX Group

Note: Failure to provide this information will result in medications to be billed to the facility until completed information is received.

- ☐ Verified signed orders by Prescriber or Telephone Order Documentation (MD/RN)
- ☐ Order duration indicated (ALF/Group Home/Res Care only)
- ☐ Valid prescriptions for controlled substances (CII-CV)
- ☐ Level of Care is specified (SNF/NF if applicable)
  - ☐ **If SNF Level of Care please included Discharge Summary for Pharmacist to perform Initial Medication Reconciliation and Initial Review *(required by regulation)***
  - ☐ **If SNF Level of Care please indicate Payor Source:**

Medicare____ Mainecare____ Private Pay____ Other_____

Medications needed (please indicate below):

- ☐ All
- ☐ All RX/No OTC
- ☐ Profile ONLY
- ☐ Specific Med(s) listed:

- ☐ Any IV's or Compound Medications?

  Yes___ No___

_____

_____

_____

_____

_____