

PART II APPLICATION FOR ADMISSION

PREADMISSION MEDICAL SCREENING

APPLICANT NAME: _____

PHYSICIAN: _____

ADDRESS: _____

TELEPHONE: _____

The following information is needed to determine medical eligibility for Admission for the above-named person:

MOST RECENT HISTORY AND PHYSICAL

PROBLEM LIST AND ALLERGIES

CURRENT MEDICATIONS

MOST RECENT DIAGNOSTIC TEST (LABS, X-RAY, ETC.), COMPLETED WITHIN THE LAST 90 DAYS.

DATE(S) OF LAST HOSPITALIZATIONS AND DIAGNOSES TREATED

IMMUNIZATION RECORD/CURRENT STATUS

This information can be faxed to: **Director of Admissions (732-846-1089)** or mailed to:

McCarrick Care Center

15 Dellwood Lane

Somerset, New Jersey, 08873