A black and white image of a horseshoe

Description automatically generated

6565 Babcock Trail, Inver Grove Heights, MN 55077

Main Phone: 612-350-7989 Director Phone: 269-491-1870 [www.thebardo.com](http://www.thebardo.com/)

Email: christin@thebardo.com

From:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sender’s Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NECESSARY DOCUMENTS TO REVIEW FOR ADMISSION o Completed application form.

* FACE sheet including payer information.
* DNR/DNI/Allow for Natural Death
* Most recent H&P from a hospital/clinic including progress notes listing comorbidities and evidence of terminal disease.
* Verification of hospice enrollment
* Information from clinician / or HPI indicating the following:
  + Recent Scans/Imaging
  + Functional Status (PPS/Karnofsky score)
  + Copy of Advanced Healthcare Directive or Power of Attorney

If you have any questions, please contact:

Christin Ament @ christin@thebardo.com

612-350-7989

*The Bardo is a licensed end-of-life home that does NOT change medical treatment laid out by the hospice agency, yet offers comfort and support to those who are deemed terminal. This facility does not discriminate because of race, color, creed, religion, sex, age, physical or mental disability, national origin, marital status or sexual orientation.*

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE\_\_\_\_\_\_\_\_\_RACE\_\_\_\_\_\_\_\_\_\_\_\_\_RELIGION\_\_\_\_\_\_\_\_\_

PHONE#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AFFILITATED HOSPICE AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME OF SPOUSE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL SECURITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TERMINAL DIAGNOSIS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY SITE (IF CANCER)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF ONSET\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROGNOSIS IN DAYS/WEEKS IF KNOWN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRIEF HISTORY OF ILLNESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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CO-MORBIDITIES/SECONDARY DIAGNOSES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTAGIOUS OR COMMUNICABLE

DISEASE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S CURRENT

LOCATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMMUNICATION:   
ABLE TO SPEAK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
SPEAKS ENGLISH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NEEDS INTERPRETER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACTIVITY LEVEL: COMPLETE BED PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMBULATORY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHAIR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SMOKER: CURRENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FORMER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NON-SMOKER\_\_\_\_\_\_\_\_\_\_\_

HISTORY OF MENTAL ILLNESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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HISTORY OF VIOLENT BEHAVIOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DELERIOUS\_\_\_\_\_\_\_\_\_\_SUSPICIOUS\_\_\_\_\_\_\_\_\_\_\_\_\_BELLIGERENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALCOHOL/CHEMICALLY DEPENDENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIET: REGULAR\_\_\_\_\_\_\_\_\_\_\_\_ SPECIAL\_\_\_\_\_\_\_\_\_\_\_\_TUBE FEEDING\_\_\_\_\_\_\_\_\_\_\_\_\_

ELIMINATION: CONTINENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INCONTINENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOLEY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_COLOSTOMY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UROSTOMY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WEIGHT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEVEL OF CONSCIOUSNESS:

ALERT\_\_\_\_\_\_\_\_\_\_\_LETHARGIC\_\_\_\_\_\_\_\_\_UNRESPONSIVE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MOOD/BEHAVIOR:

DEPRESSED\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONFUSED\_\_\_\_\_\_\_\_\_\_\_\_NOISY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

QUIET\_\_\_\_\_\_\_\_\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUPPLIES/EQUIPMENT: OXYGEN\_\_\_\_\_\_\_\_\_\_ SUCTION\_\_\_\_\_\_\_\_\_\_

PLEURUX\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIAL MATTRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_TRACH TUBE\_\_\_\_\_\_\_\_\_\_\_CPAP\_\_\_\_\_\_\_\_\_\_\_\_

OTHER\_\_\_\_\_\_\_\_

CODE STATUS/POLST/ADVANCED DIRECTIVE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPOINSIBLE PARTY/HEALTHCARE AGENT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL/PRIMARY PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECOND

PERSON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL/PRIMARY

PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL

WORKER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*DOCUMENTATION REQUIREMENTS: DO NOT RESUSICTATE (DNR)/DO NOT INTUBATE (DNI)/ALLOW NATURAL DEATH. APPLICATION SIGNED BY A*

*PHYSICIAN OR NURSE PRATITONER. MOST RECENT MEDICATION LIST.*

*AFFILIATED HOSPICE ENROLLMENT PROOF. MOST RECENT HISTORY AND PHYSICAL FROM A HOSPITAL OR CLINIC. PROGRESS NOTE WITH PAST MEDICAL HISTORY, COMORBIDITIES AND EVIDENCE OF TERMIANL DISEASE. RECENT CT/MRI/PET SCANS, COPY OF ADVANCED DIRECTIVE IF PRESENT.*

ADMISSION CONTACT: Christin Ament at christin@thebardo.com

612-350-7989