



# ANANDAM

A JOYFUL RETREAT FOR SENIOR LIVING

2153 Nayabad, Mukundapur, Kolkata 700099

MANAGED BY

Anandam Home  
Welfare Organisation

ENQUIRIES TO

SHIMUL BHOWMIK  
9830342242

Website : [www.anandamhome.com](http://www.anandamhome.com)

## PROFESSIONAL ADMISSION, RESIDENT & MEDICAL RECORD

|                       |                                                        |
|-----------------------|--------------------------------------------------------|
|                       | <p>[ Recent Passport-size Photograph of Resident ]</p> |
| <p>Admission No.:</p> | <p>Date of Admission: ____ / ____ / ____</p>           |

### SECTION 1: ADMISSION & RESIDENT IDENTIFICATION

|                                  |                                                                                                                                                           |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Application / Enquiry No.</p> |                                                                                                                                                           |
| <p>Full Name of Resident</p>     |                                                                                                                                                           |
| <p>Date of Birth / Age</p>       | <p>____ / ____ / ____ Age: ____ years</p>                                                                                                                 |
| <p>Gender</p>                    | <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other / Prefer not to state</p>                                 |
| <p>Marital Status</p>            | <p><input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced / Separated</p> |
| <p>Nationality</p>               |                                                                                                                                                           |
| <p>Government ID Type / No.</p>  |                                                                                                                                                           |
| <p>a) Aadhar</p>                 | <p>a)</p>                                                                                                                                                 |
| <p>b) Voter Card</p>             | <p>b)</p>                                                                                                                                                 |
| <p>c) Pan Card</p>               | <p>c)</p>                                                                                                                                                 |
| <p>Permanent Address</p>         |                                                                                                                                                           |

|                              |                                                                                                                                      |
|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Previous Residential Address |                                                                                                                                      |
| Resident Mobile / Phone      |                                                                                                                                      |
| Email                        |                                                                                                                                      |
| Preferred Language(s)        |                                                                                                                                      |
| Education                    |                                                                                                                                      |
| Previous Occupation          |                                                                                                                                      |
| Pension / Income Source      | <input type="checkbox"/> Pension <input type="checkbox"/> Family <input type="checkbox"/> Savings<br><input type="checkbox"/> Other: |
| Approx. Monthly Support      | <input type="checkbox"/>                                                                                                             |

## SECTION 2: FAMILY / NOMINEE / EMERGENCY CONTACT

|                                      |  |
|--------------------------------------|--|
| Primary Contact & Relationship       |  |
| Address                              |  |
| Mobile / WhatsApp                    |  |
| Email                                |  |
| Secondary Contact & Relationship     |  |
| Secondary Contact Number             |  |
| Authorized Representative / Guardian |  |
| Authority / Relationship             |  |

## PERSONAL, FAMILY, SOCIAL & BACKGROUND ASSESSMENT

### SECTION 3: FAMILY & SOCIAL BACKGROUND

|                                              |                                                                                                                                                                       |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Living arrangement before admission          | <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Relatives<br><input type="checkbox"/> Other |
| Reason for admission                         |                                                                                                                                                                       |
| Family support available                     | <input type="checkbox"/> Regular <input type="checkbox"/> Occasional <input type="checkbox"/> Limited <input type="checkbox"/> None                                   |
| Emergency family availability                | <input type="checkbox"/> 24-hour <input type="checkbox"/> Daytime <input type="checkbox"/> Limited<br><input type="checkbox"/> Not available                          |
| Religious / cultural requirements (optional) |                                                                                                                                                                       |
| Food preferences / restrictions              |                                                                                                                                                                       |
| Personal habits / routine                    |                                                                                                                                                                       |
| Hobbies / interests                          |                                                                                                                                                                       |
| Preferred daily routine                      |                                                                                                                                                                       |

### SECTION 4: FINANCIAL & ADMINISTRATIVE DETAILS

|                          |                                                                                                                                                                     |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Admission / joining fee  | <input type="checkbox"/>                                                                                                                                            |
| Monthly residential fee  | <input type="checkbox"/>                                                                                                                                            |
| Medical / nursing charge | <input type="checkbox"/> / As per actuals                                                                                                                           |
| Security deposit         | <input type="checkbox"/>                                                                                                                                            |
| Other recurring charges  | <input type="checkbox"/>                                                                                                                                            |
| Payment frequency        | <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half-yearly<br><input type="checkbox"/> Annual                         |
| Payment mode             | <input type="checkbox"/> Cash <input type="checkbox"/> Bank transfer <input type="checkbox"/> UPI <input type="checkbox"/> Cheque<br><input type="checkbox"/> Other |
| Payer / Sponsor Name     |                                                                                                                                                                     |
| Payer Contact            |                                                                                                                                                                     |
| Receipt / Reference No.  |                                                                                                                                                                     |

## SECTION 5: RESIDENT PROPERTY & BELONGINGS

| Item / Description | Quantity | Condition | Estimated Value | Remarks |
|--------------------|----------|-----------|-----------------|---------|
|                    |          |           |                 |         |
|                    |          |           |                 |         |
|                    |          |           |                 |         |
|                    |          |           |                 |         |
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|                    |          |           |                 |         |

## SECTION 6: PERSONAL CARE & DAILY LIVING

| Activity | Independent | Needs Assistance | Fully Assisted | Remarks |
|----------|-------------|------------------|----------------|---------|
|          |             |                  |                |         |
|          |             |                  |                |         |
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## SECTION 7: RESIDENT PREFERENCES

Preferred room: ☐ Single ☐ Shared ☐ Ground floor ☐ Other: \_\_\_\_\_

Preferred meal timing: \_\_\_\_\_

Visiting preferences: \_\_\_\_\_

Other instructions / preferences: \_\_\_\_\_

## COMPREHENSIVE MEDICAL & HEALTH ASSESSMENT

### SECTION 8: GENERAL HEALTH INFORMATION

|                            |                                                                                                                                                                                                                                                                          |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Current general condition  | <input type="checkbox"/> Stable <input type="checkbox"/> Monitoring required<br><input type="checkbox"/> Assistance required <input type="checkbox"/> Other                                                                                                              |
| Known allergies            | <input type="checkbox"/> None known <input type="checkbox"/> Medicine <input type="checkbox"/> Food<br><input type="checkbox"/> Other                                                                                                                                    |
| Allergy / reaction details |                                                                                                                                                                                                                                                                          |
| Blood Group                | <input type="checkbox"/> A+ <input type="checkbox"/> A- <input type="checkbox"/> B+ <input type="checkbox"/> B-<br><input type="checkbox"/> AB+ <input type="checkbox"/> AB- <input type="checkbox"/> O+ <input type="checkbox"/> O-<br><input type="checkbox"/> Unknown |
| Height / Weight            | cm / kg                                                                                                                                                                                                                                                                  |
| Blood Pressure             | / mmHg                                                                                                                                                                                                                                                                   |
| Pulse                      | / min                                                                                                                                                                                                                                                                    |
| Blood Sugar / HbA1c        |                                                                                                                                                                                                                                                                          |
| Vision                     | <input type="checkbox"/> Normal <input type="checkbox"/> Spectacles <input type="checkbox"/> Reduced<br><input type="checkbox"/> Other                                                                                                                                   |
| Hearing                    | <input type="checkbox"/> Normal <input type="checkbox"/> Hearing aid <input type="checkbox"/> Reduced<br><input type="checkbox"/> Other                                                                                                                                  |
| Mobility                   | <input type="checkbox"/> Independent <input type="checkbox"/> Walking aid<br><input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed-dependent                                                                                                                  |
| Fall history               | <input type="checkbox"/> None known<br><input type="checkbox"/> Previous falls:                                                                                                                                                                                          |
| Sleep                      | <input type="checkbox"/> Normal <input type="checkbox"/> Disturbed <input type="checkbox"/> Other                                                                                                                                                                        |
| Diet                       | <input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Low-salt <input type="checkbox"/> Soft<br><input type="checkbox"/> Pureed <input type="checkbox"/> Other                                                                     |

## SECTION 9: PAST MEDICAL & SURGICAL HISTORY

[illegible]

## SECTION 10: CURRENT SYMPTOMS & SPECIAL CARE NEEDS

|                               |                               |
|-------------------------------|-------------------------------|
| Pain / discomfort             | Site:<br>Severity: _____ / 10 |
| Breathing / chest symptoms    |                               |
| Appetite / swallowing         |                               |
| Urinary / bowel concerns      |                               |
| Skin / pressure sore risk     |                               |
| Memory / orientation concerns |                               |
| Other symptoms                |                               |

## MEDICATION, DOCTOR & EMERGENCY MEDICAL RECORD

### SECTION 11: CURRENT PRESCRIBED MEDICATIONS

**Attach current prescriptions wherever available. Medicines must be administered only according to the treating clinician's instructions.**

| Medicine /<br>Generic<br>Name | Strength | Dose | Route | Timing | Purpose | Prescribing<br>Doctor |
|-------------------------------|----------|------|-------|--------|---------|-----------------------|
|                               |          |      |       |        |         |                       |
|                               |          |      |       |        |         |                       |
|                               |          |      |       |        |         |                       |
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|                               |          |      |       |        |         |                       |

## SECTION 12: MEDICATION & TREATMENT HISTORY

|                             |                                                                                                                                                                                                                    |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Recently stopped medicines  |                                                                                                                                                                                                                    |
| Known medicine side effects |                                                                                                                                                                                                                    |
| Insulin / injections        | <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Details:                                                                                                                                               |
| Regular monitoring          | <input type="checkbox"/> BP <input type="checkbox"/> Sugar <input type="checkbox"/> Oxygen<br><input type="checkbox"/> Weight <input type="checkbox"/> Other                                                       |
| Medical devices             | <input type="checkbox"/> Spectacles <input type="checkbox"/> Hearing aid <input type="checkbox"/> Dentures<br><input type="checkbox"/> CPAP/BiPAP <input type="checkbox"/> Catheter <input type="checkbox"/> Other |
| Device care instructions    |                                                                                                                                                                                                                    |

## SECTION 13: DOCTOR / SPECIALIST DETAILS

| Doctor / Specialist | Specialty | Hospital / Clinic | Phone | Last Visit | Next Visit |
|---------------------|-----------|-------------------|-------|------------|------------|
|                     |           |                   |       |            |            |
|                     |           |                   |       |            |            |
|                     |           |                   |       |            |            |
|                     |           |                   |       |            |            |
|                     |           |                   |       |            |            |

## SECTION 14: MEDICAL DOCUMENTS RECEIVED

- ☐ Prescriptions ☐ Discharge summaries ☐ Blood reports  
☐ Imaging / scans ☐ ECG / cardiac records ☐ Diabetes records  
☐ Eye records ☐ Hearing records ☐ Vaccination records  
☐ Surgery records ☐ Other

## SECTION 15: EMERGENCY MEDICAL INFORMATION

|                    |  |
|--------------------|--|
| Emergency Contact  |  |
| Preferred Hospital |  |

|                              |                                       |
|------------------------------|---------------------------------------|
| Insurance / Health Scheme    | Provider: _____<br>Policy / ID: _____ |
| Insurance Contact            |                                       |
| Known emergency instructions |                                       |
| Important medical warning    |                                       |

### SECTION 16: INITIAL MEDICAL / NURSING ASSESSMENT

| Parameter | Finding | Date / Time | Action / Advice | Staff Signature |
|-----------|---------|-------------|-----------------|-----------------|
|           |         |             |                 |                 |
|           |         |             |                 |                 |
|           |         |             |                 |                 |
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|           |         |             |                 |                 |

### RULES, REGULATIONS, FEES & RESIDENT UNDERTAKING

### SECTION 17: FEE & PAYMENT SCHEDULE

| Fee / Service | Amount | Frequency | Due Date | Included / Notes |
|---------------|--------|-----------|----------|------------------|
|               |        |           |          |                  |
|               |        |           |          |                  |
|               |        |           |          |                  |

| Fee / Service | Amount | Frequency | Due Date | Included / Notes |
|---------------|--------|-----------|----------|------------------|
|               |        |           |          |                  |
|               |        |           |          |                  |
|               |        |           |          |                  |
|               |        |           |          |                  |

#### SECTION 18: ADDITIONAL / CHARGEABLE SERVICES

| Service | Rate | Unit / Frequency | Approval Required | Remarks |
|---------|------|------------------|-------------------|---------|
|         |      |                  |                   |         |
|         |      |                  |                   |         |
|         |      |                  |                   |         |
|         |      |                  |                   |         |
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#### SECTION 19: NOTICE / REFUND / WITHDRAWAL TERMS

Notice period for voluntary discharge: \_\_\_\_\_ days.

Refund / deposit terms:

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Other withdrawal conditions:

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Emergency discharge / hospital transfer procedure:

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## **SECTION 17: GENERAL RULES & REGULATIONS**

- 1. Residents shall maintain respectful and courteous conduct toward other residents, staff, visitors and service providers.**
- 2. The resident/family shall provide accurate personal, financial and medical information and promptly report material changes.**
- 3. Prescribed medicines shall be submitted, stored and administered according to the home's medical procedure and the treating clinician's prescription.**
- 4. Residents shall attend medical reviews, investigations and hospital referrals considered necessary by the treating clinician or responsible care team.**
- 5. Visitors must follow the home's visiting hours, identification requirements and safety procedures.**
- 6. Smoking, possession of prohibited substances, weapons, hazardous items, or conduct creating a safety risk are not permitted.**
- 7. Residents shall respect privacy, personal belongings and personal space of others. Theft, harassment, threats or physical violence are prohibited.**
- 8. Electrical appliances, food items, medicines or other personal items may be restricted where they present a safety or health risk.**
- 9. Residents should not leave the premises without following the home's sign-out / permission procedure. Where applicable, an authorized representative may be required.**
- 10. Fees and additional service charges must be paid according to the agreed schedule. Receipts should be retained.**
- 11. The home may require updated medical reports, prescriptions or emergency contacts when necessary for safe care.**
- 12. The home may revise operational rules when reasonably necessary for resident safety, statutory requirements or smooth administration, with appropriate notice.**
- 13. Personal data and medical records will be handled confidentially, subject to applicable law and legitimate care, administrative and emergency requirements.**
- 14. Complaints or concerns should be raised through the home's designated grievance procedure.**

## **UNDERTAKING, CONSENT, SIGNATURES & OFFICE VERIFICATION**

### **SECTION 21: UNDERTAKING BY RESIDENT / FAMILY / AUTHORIZED REPRESENTATIVE**

I / We confirm that the information supplied in this admission form and the documents submitted with it are, to the best of my / our knowledge, complete and accurate. I / We understand that the Old Age Home relies on this information to plan accommodation, personal care, medication support and emergency response.

I / We undertake to inform the management promptly about any change in the resident's medical condition, medication, allergy, hospitalization, doctor's advice, emergency contact details, legal status, or other information that may materially affect the resident's care or safety.

I / We agree to comply with the home's applicable rules, fee schedule, visiting procedures, safety requirements and grievance procedure. I / We understand that medical treatment decisions remain subject to qualified healthcare professionals and applicable law, and that the home may seek emergency medical assistance when reasonably necessary.

I / We acknowledge receipt / availability of the home's rules, fee schedule and relevant admission information and agree to the terms applicable to the resident's admission.

## SECTION 22: CONSENT FOR CARE & RECORD KEEPING

|                             |                                                                                                                                                                         |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Resident Consent            | <input type="checkbox"/> I consent to routine personal care and assistance as agreed.<br><input type="checkbox"/> I consent to maintenance of care and medical records. |
| Medical Information Sharing | <input type="checkbox"/> I authorize relevant medical information to be shared with treating clinicians / emergency services when necessary for care.                   |
| Emergency Care              | <input type="checkbox"/> I understand that emergency medical assistance may be sought when reasonably necessary, subject to applicable law and documented wishes.       |
| Photography / Publicity     | <input type="checkbox"/> Yes <input type="checkbox"/> No Separate consent should be obtained for publicity / promotional use of photographs.                            |

## SECTION 23: SIGNATURES

| Person | Name | Signature | Date | Contact / Remarks |
|--------|------|-----------|------|-------------------|
|        |      |           |      |                   |
|        |      |           |      |                   |
|        |      |           |      |                   |
|        |      |           |      |                   |
|        |      |           |      |                   |

## SECTION 24: OFFICE VERIFICATION & ADMISSION APPROVAL

|                                   |                                                                                                                                                           |
|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Documents verified by             | Name:                                                                                                                                                     |
| Identity document verified        | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Type:                                                                                         |
| Medical documents reviewed        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                  |
| Admission interview completed     | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date:                                                                                         |
| Room / Bed No.                    |                                                                                                                                                           |
| Admission status                  | <input type="checkbox"/> Approved <input type="checkbox"/> Approved with conditions<br><input type="checkbox"/> Pending <input type="checkbox"/> Declined |
| Conditions / special instructions |                                                                                                                                                           |
| Authorized by                     | Name:                                                                                                                                                     |
| Designation                       |                                                                                                                                                           |
|                                   |                                                                                                                                                           |

|                           |  |
|---------------------------|--|
| Signature / Official Seal |  |
|---------------------------|--|

#### CONFIDENTIALITY & RECORD CONTROL

**Resident records should be securely maintained and accessed only by authorized personnel and persons legally entitled to receive the information, subject to applicable privacy, medical-record and elder-care requirements. This form should be adapted to the home's local legal and regulatory requirements before use.**

