地域密着型介護老人福祉施設

**特別養護老人ホーム大野和幸園入居申込書**

**令和 年 月 日**

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| **入所希望者**  **氏 名** | **ふりがな** | | | | | | |  | | | | | | | | | | | | | | | | | | | **明治　・　大正　・　昭和** | | | | | | | | | | | | | | **男 ・ 女** | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | **年　　　月　　　日生** | | | | | | | | | | | | | | **歳** | | | |
| **住 所** | **〒** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **申 込 者**  **氏　名** | **ふりがな** | | | | | |  | | | | | | | | | | | | | **続 柄** | | | | | | | **男 ・ 女** | | | | | **連 絡 先** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | **歳** | | | | |  | | | | | | | | | | | | |
| **１．現在の状況** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **自宅療養中** | | | | | | | | | | | | | | **病院入院中（** | | | | | | | | | **年 　　月 　　日** | | | | | | | | | | **頃から）** | | | | | | | | | | | |
| **主介護者（** | | |  | | | | | | | **）　病院名（** | | | | | | | |  | | | | | | | | | | | **）　担当相談員（** | | | | | |  | | | | | | | | **）** | |
| **施設入所中（** | | | | **年 　　月 　　日** | | | | | | | | | | | **頃から）** | | | | | | | | | | | | | | | | | **その他** | | | | | | | | | | | | |
| **施設名（** | |  | | | | | | | | | | | **）　担当相談員（** | | | | | | | |  | | | | | | | | | | | **）** | | | | | | | | | | | | |
| **２．介護保険被保険者証　　　　申請済　　　　　　申請中　　　　　 　未申請** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **被保険者番号 ［** | | | | | |  | | | | | | | | | | | **］　保険者 ［** | | | | | | |  | | | | | | | **］** | | | | | | | | | | | | | |
| **要支援･要介護区分　要介護1　・　要介護2　・　要介護3　・　要介護4　・　要介護5** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **申請中** | | | | | | |
| **認定の有効期間** | | | | | **年　　　月　　　日** | | | | | | | | | | | | **～** | | | | | | | | **年 　　月 　　日** | | | | | | | | | | | | | |  | | | | | |
| **負担割合証　　　1割　・　　2割　・　　3割** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **負担限度額認定　　第1段階　・　第2段階　・　第3段階①　・　第3段階②　・　第4段階** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **申請中　　 未申請** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **居宅介護支援事業所事業所名（** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | **）　担当ケアマネ（** | | | | | | | |  | | | | | | | | **）** |
| **３．健康保険証及び手帳の種類** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **国保　・　社保　・　後期高齢者　・　その他（** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | **）** | | | | | | | | | | | | | | |
| **障害者手帳　　　有　　・　　無** | | | | | | | | | | | **交付年月日** | | | | | | | | **年　　　月　　　日** | | | | | | | | | | | **種別** | |  | | | | | **種** | | |  | | **級** | | |
| **４．経済状況** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **年金恩給等の種類　(** | | | | | | |  | | | | | | | | | | | | | | | | | | | **)　　月平均受領額：** | | | | | | | |  | | | | | | | | | **円** | |
| **５．本人の同意** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **同意している　・　同意していない　・　意志疎通困難（** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | **）** | |
| **6．他施設への申込み状況** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **申込みなし　当該のみ申し込む** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **申込み（予定）あり　（　　　　　　　　　　　　　　　）（　　　　　　　　　　　　　　　）（　　　　　　　　　　　　　　　）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **７．入所を希望する理由** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **身寄りがいないなど介護する者がいないため** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **介護する者が地理的に離れている、もしくは病院等に長期入院するなどの状況により介護が不能** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **介護する者はいるが、要介護状態、高齢等の状況にあり、十分な介護が困難** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **介護する者はいるが、要支援状態、高齢等の状況にあり、十分な介護が困難** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **介護する者はいるが、複数の介護や育児を行っているなど、十分な介護が困難** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **介護する者はいるが、就業しているため、十分な介護が困難** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

※　裏面への記入もお願いします。

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **8．病歴について** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **（発症年月日 ：** | | | | | | |  | | | | | | | | | | | | **/ 病名 ：** |  | | | | | | | | | | | | | | | | | | | | **)** |
| **（発症年月日 ：** | | | | | | |  | | | | | | | | | | | | **/ 病名 ：** |  | | | | | | | | | | | | | | | | | | | | **)** |
| **（発症年月日 ：** | | | | | | |  | | | | | | | | | | | | **/ 病名 ：** |  | | | | | | | | | | | | | | | | | | | | **)** |
| **（発症年月日 ：** | | | | | | |  | | | | | | | | | | | | **/ 病名 ：** |  | | | | | | | | | | | | | | | | | | | | **)** |
| **9．ご本人様の状態** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **食事　：** | | | **自立** | | | | | | **一部介助** | | | | | | | | | **全介助** | | | | | | **胃瘻** | | | | |  | | | | | |  | | | | | |
| **排泄　：** | | | **自立** | | | | | | **一部介助** | | | | | | | | | **全介助** | | | | | | **バルンカテーテル** | | | | | | | | | | | **ストマ** | | | | | |
|  | | | **トイレ** | | | | | | **紙パンツ** | | | | | | | | | **ポータブルトイレ** | | | | | | | | | | | **紙オムツ** | | | | | | | | | | | |
| **移動　：** | | | **自立** | | | | | | **一部介助** | | | | | | | | | **全介助** | | | | | |  | | | | |  | | | | | |  | | | | | |
|  | | | **独歩** | | | | | | **杖** | | | | | | | | | **歩行器** | | | | | | **車椅子** | | | | | **（　　自操** | | | | | | **介助　）** | | | | | |
| **移乗　：** | | | **自立** | | | | | | **一部介助** | | | | | | | | | **全介助** | | | | | |  | | | | |  | | | | | |  | | | | | |
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| **〔 認知症による行動障害 〕** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **該当なし** | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | |  | | | | |
| **徘徊** | | | | | **不潔行為** | | | | | | | | | | **不穏行動** | | | | | | | **自傷行為** | | | | | | | | **暴力行為** | | | | | | **昼夜逆転** | | | | |
| **異食** | | | | | **幻視、幻覚** | | | | | | | | | | **被害妄想** | | | | | | |  | | | | | | | |  | | | | | |  | | | | |
| **〔 医療処置 〕** | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | |  | | | | |
| **酸素** | | | | | **点滴** | | | | | | | | **吸引 （** | | | | |  | | | | | | | | | **）** | **インスリン注射** | | | | | | | | | | | | |
| **(** |  | | | | | | | | | | | | | **)** | |  | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| **〔 新型コロナワクチン接種 〕** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **未接種** | | | | | |  |  | | | | **回接種済み** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **（　①** | |  | | | | | | **②** | |  | | | | | | | **③** | |  | | | | | | **④** |  | | | | | | **⑤** |  | | | | | | **）** | |
| **１０．居室の希望について** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **多床室** | | | | **個室** | | | | | | | | **どちらでも可** | | | | | | | | | | | | | **ショートステイ利用　：** | | | | | | | | | **可** | | | | **不可** | | |

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| **身元保証人**  **氏 名** | **ふりがな** | |  | | | | **続 柄** | | **明治 ・ 大正 ・ 昭和 ・ 平成** | | | | **男 ・ 女** |
|  | | | | | |  | | **年　　　月　　　日生** | | | | **歳** |
| **住 所** | **〒** | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| **勤務先** |  | | | | | | | | | | | | |
| **連絡方法** | **①（ 自宅 ・ 携帯 ・ 勤務先 ・ その他〔** | | | | | |  | | | **〕） TEL** |  | | |
| **②（ 自宅 ・ 携帯 ・ 勤務先 ・ その他〔** | | | | | |  | | | **〕） TEL** |  | | |
| **主介護者**  **氏 名** | **ふりがな** |  | | | | | **続 柄** | | **明治 ・ 大正 ・ 昭和 ・ 平成** | | | **男 ・ 女** | |
|  | | | | | |  | | **年　　　　月　　　　日生** | | | **歳** | |
| **家　族** | **氏 名** | | | | **続 柄** | **年 齢** | | **連 絡 先** | | | | | |
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