Kāhala Nui

CONFIDENTIAL DATA PROFILE

ALL INFORMATION WILL BE HELD CONFIDENTIAL

Directions: Please answer each question as thoroughly as possible. If you are applying for double occupancy, each person is required to complete his or her own profile.

1. Name: ____
   Prefix Last First Middle

2. Address:____
   Street City State Zip

3. Telephone No.: (____) ________________________ Mobile No.: (____) ______________________

4. Email Address: ____
   Do you want your email address listed in the Resident Website Phone Directory after moving to Kāhala Nui? ___yes ___no

5. Birth Date: ____ Current Age: ________
   Month Day Year

6. Marital Status: _____ Married _____ Single _____ Widowed _____ Divorced

7. Name of Spouse: ____

8. No. of children: _______ (Contact Information for children is *required*. Complete page 7.*)*

9. Do you have a Durable Power of Attorney? ______yes ______no

10. Do you have an Advanced Healthcare Directive? ______yes ______no

11. Do you have a Provider Orders for Life-Sustaining Treatment (POLST) form? ______yes ______no

12. Name of Power of Attorney (POA) – Other than Spouse *(Required)*:___________________________

    Relationship of POA: ____________________________ Email Address_______________________

    Telephone No.: (____) ______________________ Mobile No.: (____) ______________________

    Address: ____
    Street City State Zip

12a. Name of Attorney who prepared Power of Attorney Documents:

    ____

Confidential Data Profile Continued:

13. FIRST person to notify in case of emergency: ____

Relationship: ___________________________ Email Address___________________________

Address: ____
Street City State Zip

Telephone No.: (____) _____________________ Mobile No.: (____) _____________________

14. SECOND person to notify in case of emergency: ____

Relationship: ___________________________ Email Address___________________________

Address: ____
Street City State Zip

Telephone No.: (____) _____________________ Mobile No.: (____) _____________________

15. What is/was your occupation?____

16. Veteran: _____yes _____no If YES, what Branch of Service:______________________________

17. What are your hobbies or interests: ____

18. Church Affiliation: (Optional) ____

19. Would you bring a car? _____yes _____no Electric car? ______yes ______no

20. Would you be bringing a pet? If YES, please describe your pet.
____

21. Have you ever been convicted of or pleaded nolo contendere to a felony or other crime other than a traffic violation? _____yes _____no

If you have answered YES, please provide an explanation on a separate sheet.

22. Are you capable of Independent Living without help from anyone else, paid or unpaid?
_____yes _____no

If NO, please describe the kinds of assistance you currently need.

____

____

Confidential Data Profile Continued:

23. Medicare No.: ____ (Hospital A ______ Medical B ______)
Check all that applies.

Supplemental Health Insurance:

Insurer: ________________________________ Policy No.: ________________________________

Long Term Care Insurance: ____

24. Health History: Please list all medical conditions (current/past) including any surgery or procedure you may have had.

____

____

____

____

____

____

____

____

____

25. Have you received your COVID-19 vaccine? _____yes _____no

If yes, which one? ___________________
If Pfizer or Moderna, have you had both doses? _____yes _____no

When did you receive your last dose? _______________________

26. Please provide name, address, telephone and fax number of your primary care physician (PCP):

Name: ____

Address: ____
Street City State Zip

Telephone No.: (____) _______________________ Fax No.: (____) ________________________

Last Seen: ____

Confidential Data Profile Continued:

27. List all other physicians you see on a regular basis:

Physician: ________________________________ Specialty: ______________________________

Address: ____
Street City State Zip

Telephone No.: (____) _________________________ Fax No.: (____) ____________________________

Last Seen: ____

Physician: ________________________________ Specialty: ______________________________

Address: ____
Street City State Zip

Telephone No.: (____) _________________________ Fax No.: (____) ____________________________

Last Seen: ____

Physician: ________________________________ Specialty: ______________________________

Address: ____
Street City State Zip

Telephone No.: (____) _________________________ Fax No.: (____) ____________________________

Last Seen: ____

Physician: ________________________________ Specialty: ______________________________

Address: ____
Street City State Zip

Telephone No.: (____) _________________________ Fax No.: (____) ____________________________

Last Seen: ____

(Please list any other physician(s) you are currently seeing on a separate sheet.)

Preferred Hospital: _______________________________

28. Have you been hospitalized or incapacitated within the last 5 years? _____yes _____no

If YES, please explain such details as necessary to understand the condition and outcome.

____

____

____

Confidential Data Profile Continued:

29. Have you ever been treated for depression, anxiety, or any other emotional disorder?
_____yes _____no If YES, please explain:

____

____

____

30. Are you free from contagious disease? _____yes _____no

31. Have you ever been treated for alcoholism or drug dependency? _____yes _____no

If YES, please explain: ____

____

____

32. List all current medications, including those prescribed by a physician, over-the-counter and herbals.

Medication	Strength	Directions	Medical Reason

33. Medications: Do you manage your medications? ______yes ______no

Does someone assist you by setting up your pill box or medication reminders? ____yes ____no

34. Do you have any visual impairment or limited vision due to health reasons? _____yes _____no

If YES, please explain: ____

____

Confidential Data Profile Continued:

35. Do you have any significant hearing loss? _____yes _____no

    Do you use hearing aids? _____yes _____no

36. Do you use any assistive devices such as a walker, cane, or scooter? _____yes _____no

37. Do you require continuous or intermittent oxygen? _____yes _____no

38. Are you at risk for falling and have you been hospitalized for a fall? _____yes _____no
    If YES, please explain:

    ____

    ____

    ____

39. Please list all Allergies (include food, medication, other).

    ____

    ____

    ____

    ____

40. Do you require a special diet or special consistency (minced, chopped, puree) due to swallowing difficulties or health reasons?

    ____

    ____

    ____

    ____

To the best of my knowledge, the above statements are complete and true. By signing this Confidential Data Profile, I authorize Kāhala Senior Living Community, Inc. (KSLC) to contact the physicians listed herein and authorize those physicians to disclose my medical information to KSLC.

____ ____________________________
Prospective Resident Signature Date

Confidential Data Profile Continued:

Contact information for all children *(Required)*:

____
Last Name First Name

____
Street City State Zip

Telephone No.: (____) ______________________________ Mobile No.: (____) _____________________________

Email Address: ____

____
Last Name First Name

____
Street City State Zip

Telephone No.: (____) ______________________________ Mobile No.: (____) _____________________________

Email Address: ____

____
Last Name First Name

____
Street City State Zip

Telephone No.: (____) ______________________________ Mobile No.: (____) _____________________________

Email Address: ____

____
Last Name First Name

____
Street City State Zip

Telephone No.: (____) ______________________________ Mobile No.: (____) _____________________________

Email Address: ____

____
Last Name First Name

____
Street City State Zip

Telephone No.: (____) ______________________________ Mobile No.: (____) _____________________________

Email Address: ____