

# LINN HAVEN

## REHAB & HEALTHCARE



*"Where caring makes the difference"*

530 South Linn Avenue  
New Hampton, IA 50659  
641-394-3151

### ROOM CHANGE NOTICE FOR :

RESIDENT'S NAME \_\_\_\_\_

*Each Resident, and, if known, the Resident's legal representative/responsible party, has the right to receive notice before the Resident's room or roommate in the facility is changed.*

Telephone     Personal    Discussion & Response: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Telephone Notice/Consent: \_\_\_\_\_ Time: \_\_\_\_\_

I, \_\_\_\_\_, RESIDENT'S NAME \_\_\_\_\_, hereby consent to

Move from Room # \_\_\_\_\_ to Room # \_\_\_\_\_.

Stay in Room # \_\_\_\_\_ and acquire a new roommate: \_\_\_\_\_.

I hereby agree to waive the 48-hour notice of this room change. *(Check if applicable)*

**Resident \* :** \_\_\_\_\_ **Date:** \_\_\_\_\_

Resident is physically unable to sign.       Resident is cognitively unable to sign  
 Resident prefers to allow his/her Responsible Party to sign

**Resident/Responsible Party:** \_\_\_\_\_

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

**Director of Nursing:** \_\_\_\_\_

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

**Social Services Coordinator:** \_\_\_\_\_

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

Current Roommate: \_\_\_\_\_  Notification has been completed. (check if applicable)

New Roommate: \_\_\_\_\_  Notification has been completed. (check if applicable)

Date Move Completed: \_\_\_\_\_