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: _____