INITIAL INTAKE ASSESSMENT

CLIENT NAME:_____ VISIT DATE:_____ DUE DATE:_____

VAU REP.:_____ PHONE:_____ EFF. DATE:_____

MLTC REP:_____ PHONE:_____

CLIENT ADDRESS:_____ PHONE:_____ CELL:_____

LANGUAGE:_____ S.S.#:_____ SURPLUS:_____

MEDICAID #:_____ SEQ:_____ MEDICARE #:_____

COUNTRY OF ORIGIN_____ DATE OF BIRTH:_____

HRS AUTH:_____ DAYS:_____ D.F._____ BILL HRS._____

EMERGENCY CONTACT:

1) NAME:_____ ADDRESS:_____

PHONE #:_____ ALT. PHONE:_____ KEY_____

RELATION:_____ AVAILABILITY:_____

2) NAME:_____ ADDRESS:_____

PHONE:_____ ALT. PHONE:_____ KEY:_____

RELATION:_____ AVAILABILITY:_____

3) HAS CLIENT RECEIVED HCS IN THE PAST OR CURRENTLY RECEIVING:

IF YES: VENDOR NAME:_____ TEL. #:_____

PRESENT AT INTERVIEW:_____ SOURCE OF INFO._____

OTHERS IN HOUSEHOLD:

1) NAME:_____ RELATION:_____ AGE:_____
2) NAME:_____ RELATION:_____ AGE:_____
3) NAME:_____ RELATION:_____ AGE:_____
4) NAME:_____ RELATION:_____ AGE:_____

Does anyone in the home require child care? YES ( ) NO ( )

PETS: YES ( ) NO ( ) If yes, who cares for pet_____ What kind of pet?_____

Environment/Pose difficulty for tasks completion:

_____

_____

LIVE-IN ACCOMODATION: YES ( ) _____ NO ( ) _____

SLEEPING:_____ SPACE:_____ PRIVACY:_____

SMOKING IN THE HOME:_____

ALCOHOL/RECREATIONAL DRUGS:_____

RELIGION:_____

DOCTORS/CLINIC

1) NAME:_____ SPECIALTY:_____

ADDRESS:_____ PHONE #:_____

2) NAME:_____ SPECIALTY:_____

ADDRESS:_____ PHONE #:_____

3) NAME:_____ SPECIALTY:_____

ADDRESS:_____ PHONE #:_____

PRIMARY HOSPITAL:_____ NEAREST:_____

MD VISITS/HOW OFTEN:_____ DIET:_____

ALLERGIES:_____ WEIGHT:_____ HEIGHT:_____

PHARMACY:_____ PHONE #:_____

ADDRESS:_____

AMBULETTE/CAR SERVICE_____

DIALYSIS: YES ( ) NO ( )

CENTER:_____

DAY

PROGRAM:_____

DIAGNOSIS: / ICD 10 Code

SYMPTOMS:

MOST RECENT HOSPITALIZATION:

CLIENT COMPLIANT:

HX OF SURGERIES:

PHYSICIAN HX: DX

HOSPITAL ADMITS:

CURRENT THERAPY:

ENDANGERING BEHAVIORS:

IMPAIRMENTS:

SPEECH DOM HAND OTHER
LE CARDIAC RESP

CONTINENCE: URINE BOWEL

COGNITIVE: JUDGEMENT

ABLE TO LEARN: ABLE TO DIRECT:

PREFERENCE: TIME OF RISING BATH BREAKFAST
LUNCH DINNER BED

AMBULATION
MEMORY
ANXIETY/DEPRESSION
DILUSIONS
HALUCIN
SUNDOWNERS

WANDERING_____

FALLS_____

WHO IS RESPONSIBLE FOR FINANCES_____

WHO IS RESPONSIBLE FOR GROCERIES_____

WHO OPENS DOOR _____

CAN CLIENT BE LEFT ALONE _____

VISION_____ HEARING_____

DME: HAS _____

_____

NEEDS _____

MEDS:_____

_____

_____

_____

_____

WHO MANAGES MEDS:_____

_____

DISCUSS:

1) RN ROUTINE VISITS_____
2) COORDINATOR VISITS_____
3) CLOCK IN/OUT_____
4) RULES FOR KEYS_____
5) VALUABLES_____
6) BENEFIT CARD_____
7) LAUNDRY IN/OUT_____
8) ESCORT EXPENSE_____
9) PHONE TYPE LAUND/CELL_____

FIRE EXTINGUISHER_____ FIRE EXIT_____

SMOKE ALARM_____ CARBON MONAXIDE_____