



The Gathering Place Home Care Intake Form

Form Completed by _____ Date: _____

Participant Name _____ DOB _____

Address _____ Phone _____

_____ Soc Sec # _____

Referred By _____ Reason _____

Living Situation: Please Circle Alone | With Family | With Others _____

Emergency Contact #1 Name | Relationship _____

Telephone: Home _____ Work _____ Cell _____

Emergency Contact #2 Name | Relationship _____

Telephone: Home _____ Work _____ Cell _____

Proposed Funding: | Grant | LTC insurance | Private Pay

Primary Insurance _____ Secondary Insurance _____

DPOA / DNR

Durable Power of Attorney: Name _____ Copy Received? YES or NO

Advanced Directives: YES or NO Copy Received? _____ DNR: YES or NO Copy Received? _____

PROPOSED SCHEDULE:

Start Date _____ Day(s) of Wk. Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday

Number of Hours: _____

COMMENTS/NEEDS

Intake Health Summary

Physicians Name _____ Phone Number _____ Fax _____

Other Physicians/Mental Health Professionals _____

Primary Diagnosis _____

Are you in pain? YES or NO | Location(s) _____



Medication/Allergies _____

Surgeries/Hospitalizations in the last year _____

Infections:

- H/O MRSA
- H/O C-Diff
- Diarrhea
- UTI
- Respiratory
- Eye/Ear

Wounds: YES or NO

Is the drainage from the wound contained? _____

Location _____

What kind of dressing is being used? _____

Behavioral Needs :

H/O Aggression and/or Combativeness? YES or NO

H/O Verbal Inappropriateness? YES or NO

Wanders? YES or NO | Transmitter needed? YES or NO | Transmitter # _____

Please check the following:

- | | |
|--|--|
| <input type="checkbox"/> Toileting Independence? YES or NO | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Wears Depends | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Catheter/Ostomy | <input type="checkbox"/> Mobility devices used |
| <input type="checkbox"/> Oxygen? YES or NO | W/C cane walker |
| Liters/Min _____ | <input type="checkbox"/> Ambulation assist |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Dietary: |
| How often _____ | Needs assistance? YES or NO |
| <input type="checkbox"/> Dizziness/Loss of balance | Ground Cut-up Thickened liquids |
| <input type="checkbox"/> Fall risk | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing Problems | |