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:

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