1-800-9-GET-HELP
Fax: 212-290-3082

www.partnersincareny.org

HOME CARE INTAKE FORM

REFERRER INFORMATION

NAME / RELATIONSHIP		**TELEPHONE #**	
HOW DID YOU HEAR ABOUT US?		**DATE**	

CLIENT INFORMATION

LAST NAME				**FIRST NAME**			
STREET ADDRESS				**CITY**			
STATE		**ZIP CODE**				**SSN**	
TELEPHONE #		**DOB**		**AGE**		**SEX**	
EMERGENCY CONTACT				**RELATIONSHIP**			
ADDRESS				**TELEPHONE #**			
SERVICE INTEREST	☐ **HHA** ☐ **ESCORT** ☐ **NURSING** ☐ **BATH** ☐ **PRI** ☐ **OTHER**_____						
FUNDING SOURCE	☐ **Private Pay** ☐ **Long Term Care Insurance** ☐ **Combination (Private Pay & Medicare)**						

PHYSICIAN INFORMATION

PHYSICIAN NAME			
STREET ADDRESS		**CITY**	
STATE		**ZIP CODE**	
TELEPHONE #		**FAX #**	
PT LAST VISIT		**DIAGNOSIS**	

Language ☐ English ☐ Spanish ☐ Other, Specify _____	**Home Equipment** ☐ Hospital Bed ☐ Hoyer Lift ☐ Portable Commode ☐ Respirator ☐ None ☐ Other_____	**Mental Status** ☐ Alert ☐ Confused ☐ Forgetful ☐ Depressed ☐ Comatose ☐ Verbally Abusive/ Agitated	**Mobility Status** ☐ Independent ☐ Needs Assistance ☐ Walker ☐ Cane ☐ Wheelchair ☐ Bed bound ☐ Transfers
Impairments ☐ Speech ☐ Hearing ☐ Vision ☐ Paralysis, Specify _____ ☐ Adaptive Devices _____ ☐ Respiratory	**Impairments** ☐ Contracture ☐ Bed Sores ☐ Seizure ☐ Swallowing ☐ Other, specify_____ ☐None	**Patient Diet** _____ **Specify needs not requested** _____ _____	**Social Support System** ☐ Lives Alone ☐ Lives with _____Spouse _____Significant Other _____Pets, specify type#_____ Who cares for pets? _____

Plan of Care	**Indep**	**Partial Depend**	**Total Depend**		**Indep**	**Partial Depend**	**Total Depend**		**Indep**	**Partial Depend**	**Total Depend**
Eating				**Dressing**				Stairs			
Meal Prep				**Medications**				Bathing			
Toileting				**Management of RX**				Cleaning/ Laundry			
Transfers				**Shopping**							
Ambulation				**Escort Outside**							

COMPLETE IF PAYOR IS OTHER THAN CLIENT

NAME		**Guarantor SSN**	
ADDRESS		**Phone #**	
CREDIT CARD # FOR CARD PAYEMENTS		**CARD EXP**	