



www.partnersincareny.org

Fax: 212-290-3099 Office: 1-888-9-GET-HELP

HOME CARE INTAKE FORM

REFERRING HEALTH CARE PROFESSIONAL

NAME / ORGANIZATION	TELEPHONE #	DATE
----------------------------	--------------------	-------------

PHYSICIAN SIGNING HOME CARE ORDERS

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

CLIENT INFORMATION

LAST NAME	FIRST NAME
STREET ADDRESS	CITY
STATE	ZIP CODE
TELEPHONE #	DOB
AGE	SEX
EMERGENCY CONTACT	RELATIONSHIP
ADDRESS	TELEPHONE #
SERVICE INTEREST	<input type="checkbox"/> HHA <input type="checkbox"/> ESCORT <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> BATH <input type="checkbox"/> PRI <input type="checkbox"/> OTHER _____
FUNDING SOURCE	<input type="checkbox"/> Private Pay <input type="checkbox"/> Long Term Care Insurance <input type="checkbox"/> Combination (Private Pay & Medicare)

<u>Language</u> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, Specify _____	<u>Home Equipment</u> <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Portable Commode <input type="checkbox"/> Respirator <input type="checkbox"/> None <input type="checkbox"/> Other _____	<u>Mental Status</u> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful <input type="checkbox"/> Depressed <input type="checkbox"/> Comatose <input type="checkbox"/> Verbally Abusive/ Agitated	<u>Mobility Status</u> <input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed bound <input type="checkbox"/> Transfers
<u>Impairments</u> <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Paralysis, Specify _____ <input type="checkbox"/> Adaptive Devices <input type="checkbox"/> Respiratory	<u>Impairments</u> <input type="checkbox"/> Contracture <input type="checkbox"/> Bed Sores <input type="checkbox"/> Seizure <input type="checkbox"/> Swallowing <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> None	<u>Patient Diet</u> <u>Specify needs not requested</u> _____ <u>Allergies:</u> _____	<u>Social Support System</u> <input type="checkbox"/> Lives Alone <input type="checkbox"/> 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 #