



Partners in Care

www.PartnersInCareNY.org

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

HOME CARE CLIENT PROFILE

REFERRING HEALTH CARE PROFESSIONAL

NAME / ORGANIZATION	TELEPHONE #	DATE
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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		APT		CITY	
STATE				ZIP CODE	
TELEPHONE #		DOB		AGE	
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)				
REQUESTED START DATE:	DAYS REQUESTED:			HOURS REQUESTED:	

Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, Specify _____ _____	Home Equipment <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 _____	Mental Status <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	Mobility Status <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
Impairments <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	Impairments <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	Patient Diet <u>Specify needs not requested</u> _____ Allergies: _____	Social Support System <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 #	
CREDIT CARD # FOR CARD PAYEMENTS		CARD EXP	