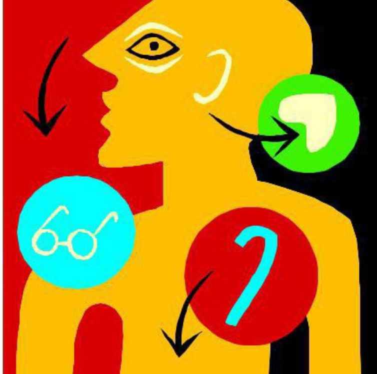
Dr. Kate Smith, GCMC
TRI-STATE CARE ALTERNATIVES
GERIATRIC CARE MANAGEMENT
INFORMATION AND REFERRAL COMPANY
(914) 388-3425/(845) 255-5118



Initial Intake Form

Data gathered is confidential and is intended only for the purpose of assisting the Geriatric Care Management Consultant in selection of the best possible direction to assist the family through the maze of services. Intake information is kept on record for maximum one (1) year.

Name:_______________________________________

Address:_____________________________________

Phone Number: ________________

Date of birth:_________ (mm/dd/year)

Height: __________ Weight: _______

Marital status: ___ (single) ___ (married) ___(partnered)
___(divorced) _____ (widowed)

Faith/Denomination: __________

Primary language spoken (English)______ (other) _____
(specify)_______________________________________

Occupation:___________________________________

Social interests: _________________________________

Hobbies, if any: _________________________________

Affiliations (clubs/organizations):____________________

____

Idiosyncrasies: __________________________________

Pets, if any (indicate N/A) if none: __________________

Dietary restrictions (ex: low salt):

____

____

Favorite foods (check off against dietary restrictions):

____

____

Foods that care recipient dislikes/cannot tolerate:

____

____

Allergies:____

Daily routine (please indicate approximate times)

Wake up: _______
Breakfast: _______
Lunch: _________
Dinner: _________
Bed: ___________

Please check off appropriate selection:

Sleep Pattern: ____ (sleeps through night) ____ (up 1-2 times) ____ (up 3+ times)

Activities During Daytime:

____

____

Primary Care Physician (Name, address & phone number)

____

____

____

Care Recipient's Hospital of Choice:

____

Medications List (can be submitted separately):

____

____

____

Emergency contacts (provide all names, numbers, and email addresses):

____

____

____

Medical diagnosis/or state physical limitations that would preclude Care Recipient from residing independently:

____

____

____

____

____

____

____

Activities of Daily Living (please indicate below with a number)

(Independent-1, Needs Assistance-2, Dependent-3, Not Applicable- N/A)
Bathing: _____
Dressing: ____
Grooming:____
Continence/Toileting: ____
Eating: ___ Additional Notes: ____________(ex: pureed food diet)
Mobility: ___
Walks With Walker: ____ Wheelchair Use: ____
Bed Bound: _____ Stands/Pivots: _____

Instrumental Activities of Daily Living

Driving Yes: ____ No:____

Phone use Yes: ____ No:____

Additional comments (if any):

____

____

____

____

Hourly Services: Yes: ____ No:____

Live-In Service: Yes: ____ No:____

Specific Requests for Care Recipient (ex: personality traits):

____

____

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