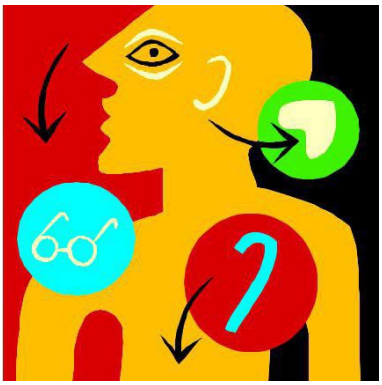

Dr. Kate Smith, GCMC
TRI-STATE CARE ALTERNATIVES GERIATRIC CARE MANAGEMENT INFORMATION AND REFERRAL COMPANY (914) 388-3425/(845) 255-5118

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: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Date of birth:_____ (mm/dd/year)

Height: ___ ft ____ in Weight: _____lbs

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

Faith/Denomination: _____
Primary Language:
(English)_____(other) ____ Please Specify: _____

Former Occupation: _____

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):
_____
_____
_____

Known Allergies (food and medications:_____
_____

Daily routine (please indicate approximate times)

Wake up: _____ Breakfast: _____
Lunch: _____ Dinner: _____
Bed: _____

Please check off appropriate selection (check <u>only</u> one):
Sleep Pattern: _____ (0-1 times/night)
_____ (1-2 times/night)*
_____ (3+ times)*
*If client gets up 2+ times per night, appropriate sleeping medication **<u>must</u>** be implemented as part of the daily regimen of the medications, <u>no exceptions.</u>

Preferred Daytime Activities:
_____
_____
_____

Primary Care Physician (Name, address & phone number)
_____
_____
_____

Care Recipient's Hospital of Choice: _____

Medications List (can be submitted separately):
_____
_____
_____
_____
_____
_____

Emergency contacts (provide <u>all</u> names, numbers, and email addresses):
Name: _____ Relationship: _____
Address: _____
Phone: _____
Email: _____

Name: _____ Relationship: _____
Address: _____
Phone: _____
Email: _____

Name: _____ Relationship: _____
Address: _____
Phone: _____
Email: _____

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

_____
_____
_____
_____
_____
_____

Activities of Daily Living (please indicate below with a <u>number</u>)
(Independent-1, Needs Assistance-2, Dependent-3, Not Applicable- N/A)
Bathing: _____ Dressing: _____
Grooming: _____ Eating: _____
Toileting: _____
Dietary Restrictions: _____ (pureed food, etc)

Ability to Ambulate (please select all that apply)
Walks With Walker: _____ Uses Wheelchair: _____
Bed Bound: _____ Stands/Pivots: _____

Please elaborate ability to ambulate (ex: can walk 150 feet with walker)

_____
_____
_____

Instrumental Activities of Daily Living (please only select Yes or No)

Driving Yes: _____ No:_____

Phone use Yes: ____ No:____

Care Recipient's Personality Traits (please outline demeanor of care recipient):

_____
_____
_____
_____
_____
_____

Service Requested (select one)
Hourly Services: Yes: ____ No: _____
Live-In Service: Yes: ____ No: _____

Hourly Services (please specify requested schedule):

Monday: From: _____ To: _____

Tuesday: From: _____ To: _____

Wednesday: From: _____ To: _____

Thursday: From: _____ To: _____

Friday: From: _____ To: _____

Saturday: From: _____ To: _____

Sunday: From: _____ To: _____

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

_____
_____
_____
_____
_____
_____