



# PACIFIC COAST HOME CARE

A SERVICE OF PACIFIC COAST HEALTH SERVICES, LLC



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www.pacificcoasthealthsvcs.com



Serving Orange County, LA and surrounding areas

## ASSESSMENT FORM

DATE OF ASSESSMENT:

Thank you for inviting Pacific Coast Home Care into your home. This assessment helps us understand your needs so we can recommend the best care and support for you or your loved one.

### 1. CLIENT INFORMATION

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

### 2. RESPONSIBLE PARTY / FAMILY CONTACT

Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Main Decision Maker?  Yes  No

### 3. REFERRAL SOURCE (How did you hear about us?)

- Hospital  Family / Friend  Doctor  
 Skilled Nursing Facility  Social Worker  Online Search  
 Other: \_\_\_\_\_

### 4. CURRENT LIVING SITUATION

- Lives Alone  With Spouse  With Family  
 Assisted Living  Apartment  House  
 Other: \_\_\_\_\_

Stairs in Home?  Yes  No

Pets in Home?  Yes  No

If yes, please describe: \_\_\_\_\_

### 5. REQUESTED SERVICES (Check all that apply)

- Personal Care Assistance  Bathing / Grooming  Dressing  
 Toileting / Incontinence Care  Meal Preparation  Light Housekeeping  
 Laundry  Medication Reminders  Transportation / Errands  
 Companion Care  Respite Care  Dementia Support  
 Overnight Care  24-Hour Care  Post-Hospital Recovery Support  
 Other: \_\_\_\_\_

### 6. MOBILITY / SAFETY

Walks Independently  Walker  Cane

Wheelchair  Bedbound

Fall History?  Yes  No If yes, when? \_\_\_\_\_

Oxygen Use?  Yes  No

Wandering Risk?  Yes  No

Need Transfer Assistance?  Yes  No

Other Safety Concerns: \_\_\_\_\_

### 7. SCHEDULE REQUESTED

Requested Start Date: \_\_\_\_\_

Days Needed: \_\_\_\_\_

Mon  Tue  Wed  Sun

Thu  Fri  Sat

Preferred Shift Hours: \_\_\_\_\_

Live-In Care Needed?  Yes  No

Care Needed:  Temporary  Ongoing

If temporary, how long? \_\_\_\_\_

### 8. GOALS / CONCERNS / ADDITIONAL NOTES

Blank area for goals, concerns, and additional notes.



Our mission is to provide compassionate, high-quality care that helps you or your loved one live safely and comfortably at home.

*Thank you!*

### ASSESSED BY

Assessed By (Name / Title): \_\_\_\_\_

Date: \_\_\_\_\_