

# HOMECARE INTAKE FORM

*Email Confidentiality Notice: The information contained in this form is privileged and confidential and/or protected health information and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). Please fax this form to 978-282-1912 with an appropriate cover sheet.*

*When anticipating discharge from a facility, PLEASE DO NOT SEND PRIOR TO THE DISCHARGE DATE.*

*Gray sections are optional, all other sections are required.*

FORM COMPLETED BY:	
NAME & TITLE:	PHONE:
ADDRESS:	EMAIL:
	FAX:
	DATE COMPLETED:
RELATIONSHIP TO CONSUMER:	
CONSUMER INFORMATION:	
NAME:	PHONE:
ADDRESS:	DOB:
ALERT & ORIENTED: <input type="checkbox"/> YES <input type="checkbox"/> NO	LIVES ALONE: <input type="checkbox"/> YES <input type="checkbox"/> NO
MARITAL STATUS: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	HOUSING TYPE: <input type="checkbox"/> OWNS <input type="checkbox"/> RENT <input type="checkbox"/> HOUSE <input type="checkbox"/> CONDO <input type="checkbox"/> APT HOUSING AUTHORITY:
SMOKES: <input type="checkbox"/> YES <input type="checkbox"/> NO	CATS: <input type="checkbox"/> YES <input type="checkbox"/> NO
CONSUMER'S EMERGENCY CONTACT	
NAME:	PHONE:
ADDRESS:	RELATIONSHIP TO CONSUMER:
HEALTH INSURANCE:	
MEDICARE: <input type="checkbox"/> YES <input type="checkbox"/> NO	MASSHEALTH: <input type="checkbox"/> YES <input type="checkbox"/> NO NUMBER:
PCP NAME:	PCP PHONE:
HOSPITAL ADMISSION IN LAST 90 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE: DATES:
REASON FOR ADMISSION:	
REHAB AFTER HOSPITAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	WHICH FACILITY:
DISCHARGE DATE:	VNA: <input type="checkbox"/> YES <input type="checkbox"/> NO WHICH VNA?
MEDICAL HISTORY (may include discharge summary/meds):	
IS CONSUMER AWARE OF THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, WHY NOT?
CALL THE CONSUMER TO COMPLETE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF NO, WHOM SHOULD WE CONTACT?	
NAME:	PHONE:
RELATIONSHIP:	
SERVICES REQUESTED:	
<input type="checkbox"/> HM <input type="checkbox"/> HDMs <input type="checkbox"/> PC <input type="checkbox"/> MEAL PREP <input type="checkbox"/> MONEY MGMT <input type="checkbox"/> LAUNDRY <input type="checkbox"/> SHOPPING <input type="checkbox"/> COMPANION	
FAMILY CAREGIVER SUPPORT GROUP? <input type="checkbox"/> YES <input type="checkbox"/> NO	OPTIONS COUNSELING? <input type="checkbox"/> YES <input type="checkbox"/> NO